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Five Years of Progress

On January 1, 1954 the Association of Registered Nurses of Newfoundland came into being — our own Association complete with an Act, an office and an executive secretary. A Provisional Council carried on the preliminary work until April when, at a general meeting, a Council was elected by the members. After our Association was officially "rolled in" at the Biennial Meeting in Banff, Alberta, we all became members of the Canadian Nurses' Association. The gavel of "Responsibility" was presented to our first President, Miss Elizabeth Summers, by the President of the Canadian Nurses' Association, Miss Helen McArthur. With the help of many nurses, we had at last reached our goal. We were members of the Canadian Nurses' Association — and we were *proud* to be members!

Today we look back with pride. We feel that our Association is firmly established. We have laid stepping-stones which have become solidly cemented and now form a foundation on which to continue to build. What has been accomplished in the past five years?

Personnel policies have been drawn up and distributed to employers of nurses.

Personnel policies have been drawn up as well for the staff of the association office.

Nurse recruitment week has been held annually. It has been received with rewarding results both in interest and enrolment.

Janet Story

Registration examinations are held twice yearly.

Policies on registration have been formed.

Two chapters, one in Corner Brook and one in St. John's, actively carry out the aims of the association during the year.

The Committee on Nursing Service sponsored an institute for head nurses this year. It was held during one of the worst storms in living memory of Newfoundlanders and much credit is due the nurses who braved snow, rain, and wind, so as not to miss a session.

The Committee on Nursing Education held a workshop, which was also well attended and enthusiastically received.

The association has reached a position where it can now afford to bring in consultants to assist us. We are pleased at being able to do this for we feel it is one way in which we can improve the nursing care to our patients.

The association has established three scholarships for prospective student nurses. The scholarships will be available to students applying for admission to schools of nursing this fall.

The members of our association who have been privileged to attend meetings on the mainland, return with new ideas and with encouragement for their own ideas. These meetings have been most helpful to us in our task of trying to improve nursing in Newfoundland. Because of our geographical position we feel rather isolated but these meetings help to draw us closer to the national scene.

Having laid our foundations, we are now ready to increase our efforts in promoting better nursing. The results of the work of a Planning Committee will direct our progress for the *next* five years. We aim to:

Establish policies for setting up a school of nursing.

Provide a Nursing School Advisory Board.

Review policies on registration.

Establish a provincial Student Nurses' Association.

Prepare a cost analysis of the education of a student nurse.

Undertake a statistical survey of nurses in Newfoundland.

Work for licensure for nursing assistants under the direction of the Registered Nurses' Association.

Hold a yearly refresher course for nurses.

Review registration examinations as to method and results.

It has been of concern to schools of nursing here that all students do not have the matriculating subjects considered necessary for nursing and postgraduate study. As a result of talks with officials of the Department of Education we have been invited to name a nurse to be a member of the Advisory Committee on Education. This representation, we feel, will help greatly in improving the academic qualifications of our student nurses.

We have expanded tremendously both in the amount of work we do and in stature. At our annual meeting in April, 1959 the matter of an increase in fees was considered. The response of the majority of the members was most gratifying. They realize how much the association has grown and how it will continue to grow. The increase was approved by the majority of those present. With such encouragement from the membership we are now ready to continue our efforts to improve nursing education and nursing service in Newfoundland.

The help from the Canadian Nurses' Association and from the other provincial associations has been invaluable. We are looking forward to the time when we will be able to be hostess to the Canadian Nurses' Association and to Canadian nurses at a biennial meeting, to show them a little of the country and life of their youngest member, Newfoundland.

JANET STORY
President
Association of Registered
Nurses of Newfoundland

If you ever find happiness by hunting for it, you will find it as the old woman did her lost spectacles, safe on her own nose all the time.

— JOSH BILLINGS

What would have become of us had it pleased Providence to make the weather unchangeable? Think of the state of destitution of the morning callers.

— SYDNEY SMITH

This is Canada

MORLEY A. R. YOUNG, M.D.

DURING the past year it has been my privilege to visit each province of this country of ours, in connection with activities of the Canadian Medical Association. I want to introduce you to parts of your country which you may not have visited. I want you to look beyond your horizon and realize what a vast land this Canada of ours is. Nationalism may be vicious, but will you not try to cultivate a pride of country without arrogance, a desire to help and to lead in a world sick with suspicion and fear? If we can, in a measure, accomplish this it will be in keeping with the anniversary that was celebrated this month.

> Four nations welded into one, with long historic past,
>
> Have found, in these our western wilds, one common life at last.
>
> Through the young giant's mighty limbs that stretch from sea to sea
>
> There runs a throb of conscious life, of waking energy;
>
> From Nova Scotia's misty coast to far Pacific shore,
>
> She wakes, a band of scattered homes and colonies no more,
>
> But a young nation, with her life full beating in her breast,
>
> A noble future in her eyes, the Britain of the West.[1]

On the coat of arms of this Dominion you will find the Latin words, *Ad mari usque ad mare*, from sea to sea. On the east the cold and rough Atlantic, on the West the smooth and warm Pacific, and in between miles and miles of ever-changing country. In the East, lies the oldest land in this hemisphere, where the foothills of the Laurentians scarcely exist and the plains of the St. Lawrence Valley end abruptly in the Laurentian Plateau. On the West the vast and rolling foothills of the recently born Rocky Mountains. Thus in our land we have the old and the new, the ancient and the more modern and you can sense it as you travel from place to place.

Other regional characteristics also become evident. There is the hospitality of the Maritimes, the conservatism of Ontario and Quebec — no reference to politics — the restlessness of the West, still a different atmosphere in British Columbia where our friends and relatives are British-born, Canadian nurtured and American influenced. Thus from St. John's, Newfoundland to Victoria, British Columbia there are local characteristics which we might note but the fact of most importance is that we are Canadians, one and all.

Our introduction to Prince Edward Island, "the million-acre farm"[2] was from the upper deck of the *Abegweit* as we approached Borden. The sea was calm, the sky a deep blue and the Island beautiful. To those of you who have never seen it, the shoreline and its cliffs are a rich brick red and the countryside so green that Ireland must have pangs of jealousy. We travelled by train from Borden to Charlottetown. For a time this allowed us to enjoy the scenery but before long the sun went down and quickly left us in the dark. Just at dusk a friendly cow, all black and white, tried to walk across a small trestle bridge but got her legs down between the ties. There she was until the train crew, and some passengers, helped her by the horns and tail, to go where she belonged.

Charlottetown is a beautiful old city. Out of our window we looked south over tree tops to the harbor and the red cliffs beyond. A little to the left we could see Government House. We visited it and noticed the slate doorstep worn deep by the feet of thousands who had crossed it on business or pleasure. We entered an historic room where a large table with chairs around it has remained as it was some 95 years ago. On a plaque on the wall we read,

> In the hearts and the minds of the

During his term of office as president of the Canadian Medical Association, Dr. Young of Lamont, Alberta, visited each of the provinces in turn. He delivered this material as the sixth Archer Memorial Lecture in October, 1958.

delegates who assembled in this room on September 1st 1864 was born the Dominion of Canada. Providence being their guide they builded better than they knew.

Some years later, in 1873, Lord Dufferin was to remark,

I found the Island in a high state of jubilation and quite under the impression that it is the Dominion that has been annexed to Prince Edward.[3]

We left "the Garden of the Gulf"[2] by air on a Sunday morning. As we gained altitude one could see the whole Island, an irregular patch of the greenest green in the blue Gulf of St. Lawrence. We were sorry to go, the friendship and the hospitality of the people of THE Island left nothing to be desired. We said we would come again. We did, and now I know that Prince Edward Island has much more to offer than potatoes!

Our plane landed in Moncton and from there we travelled south by automobile to Saint John and on to St. Andrews-by-the-Sea. It was a grand day for a car ride and we were driven across the greater part of New Brunswick. Much of this province is rather rugged, forests are still plentiful and the river valleys are beautiful. We passed many hay fields. It was the haying season and one's sense of sight and smell revealed why poets like to talk about,

Maud Muller on a summer's day
Raked the meadow sweet with hay.[4]

I did not expect to see so much unsettled country. One would think that this land could support many more settlers. Saint John is an ancient town. Many of the streets are narrow and the walls of the houses meet the cement of the sidewalks, or cobble stones as the case may be, without a blade of grass in between.

St. Andrews and the area around it is steeped in Canadian history. Here United Empire Loyalists of pedigree stock are to be found. A kind lady gave my wife a book full of local color and history. Loyalty in the days gone by had more of purpose about it than the brand we are apt to see today.

Along the banks of the St. Croix River, the French, the Indian and those of British background, be they Canadian or American, came and went. Place names tell of the people who lived and who still live in New Brunswick, Passamaquoddy Bay, Calais, Dieppe, Nauwigewauk, Manawagonish, Newcastle, Chatham, Bristol, etc.

Sweet maiden of Passamaquoddy,
Shall we seek for communion of souls
Where the deep Mississippi meanders
Or the distant Saskatchewan rolls?
Ah, no! In New Brunswick we'll find it
A sweetly sequestered nook
Where the swift gliding Skoodoowabskooksis
Unites with the Skoodoowabskook.[5]

We returned from St. Andrews to Saint John and had an opportunity of seeing the Saint John River running in the opposite direction to what it was when we went down. The famous tides of the Bay of Fundy cause this river to reverse its flow every day. It tumbles vigorously towards the sea on one occasion and up the river inland on the next. In Saint John friends were kind to us again, took us out to supper and then to the Exhibition Grounds where the sulky races were on and we watched the trotters and the pacers circle the track, on a beautiful evening of early September.

To reach our next port of call we went by one of the Princess ferry boats to Digby, Nova Scotia. It was a mill pond crossing of the Bay of Fundy. This patch of water does not always behave in such a ladylike manner. We did make the mistake of spending the previous night on the boat and listened to the sound of freight being loaded from dusk to dawn. However that was soon forgotten.

Digby is a resort town, most active during the summer months. It is located at the southern tip of the Annapolis Basin, which is entered from the Bay of Fundy by a very narrow strait known as the Digby Gut. Into the northern end of this basin flows the Annapolis River. This calls to mind "Annapolis? Oh yes, Annapolis must be defended; to be sure Annapolis should be defended. Pray, where is Annapolis?"[6] While in Annapolis Royal we visited Fort Anne and spent a short half hour in its museum where we dipped into the past before travelling on to Evangeline's country.

In the Acadian land, on the shores of the Basin of Minas,
Distant, secluded, still, the little village of Grand Pre

Lay in the fruitful valley. Vast meadows stretched to the eastward,
Giving the village its name, and pasture to flocks without number.[7]

At Digby we were treated to a shore party where lobsters and clams were prepared on the spot and dispensed by experts. The handling, on our part, of freshly boiled lobster may not have been expert but it was efficient and over 600 red shelled molluscs were consumed by some 300 people!

Our journey continued by auto to Halifax, by way of Berwick, Kentville, Wolfville, and Windsor, all towns in Nova Scotia's apple country. We bought some apples that were not the best, the best being shipped to other parts to maintain the reputation of this famous Annapolis apple country.

A person from Nova Scotia may be referred to as a "Bluenose." This nickname is derived from the MacIntyre Blue Potato, with bluish eyes and "nose." In 1787 shipments of these potatoes to Boston were invoiced as "blue noses." Sam Slick made the name popular and it remains with us to this day.

Our plane left from Dartmouth on the north shore of the Bedford Basin, on which Halifax is situated. We were late and so we tore past the north end of the harbor bridge, along the winding streets of Dartmouth, past the Imperial Oil Refineries, the R.C.A.F. Station and up the hill to the airport. We had scarcely time to weigh our luggage before we were ushered onto the plane and we were on our way to Newfoundland.

Below us was Nova Scotia, then Cape Breton Island with Prince Edward Island to the west, and then the wrinkled surface of the Gulf of St. Lawrence. Here and there on this blue expanse one could see ships of pleasure and of commerce, the occasional one large and mighty, as big as a match, bound for Europe, the occasional one small, looking like a water flea, significant of coastal trade, not venturing too far out into the deep.

In the late afternoon the rugged shores of the Avalon Peninsula came into sight and we were circling the air field of St. John's, Newfoundland. One could see at least 2,000 people around the airport as we taxied into position. It was soon evident that the welcome was not for us but for some four members of the wrestling brotherhood who were on the same plane. The identity of the "good boy" or the "bad boy" was not evident.

Dalhousie University

Newfoundland might be said to be a province of extremes, from rocks to fertile fields, from the bleak northern shores to the pleasant southern bays and inlets, from poverty to riches, with little of a so-called middle class, the oldest inhabited area of our Dominion yet the youngest member of Confederation. In the realm of the good heart however all the adjectives are in the superlative class. Newfoundland has been referred to as "a home entirely surrounded by hospitality."[8]

With the help of an automobile we reached the top of Signal Hill on the north shore of the famous narrows into the harbor of St. John's. From a tower on the top of this hill the first wireless message was received and sent, and the name of Marconi became a part of history. Standing in this spot it takes so little imagination to create an atmosphere of wonder and awe at man's ingenuity, and so much in the realm of self-control to keep from becoming emotional. Three or four hundred feet below you is the open Atlantic and 1900 miles straight ahead of you is Ireland, with nothing in between but water.

Gander Airport is a crossroads of the world. Here, one sees signs in many languages, airplanes from many countries, costumes of many races.

Petty Harbor, Nfld.

Here is a ceaseless going and coming from the ends of the earth. One's curious nature asks quietly, "To what end?"

Leaving Gander, we circled to the west over rocky hills, with myriad lakes and streams, the forest becoming heavier as we approached the green fields of the western side of the island. We landed for a few minutes at Stephenville which is obviously an U.S.A.F. station with R.C.A.F. visitors around. The swell from St. George's Bay wet the western end of the runway as we rose above it on our way "up along" as a Newfoundlander would say. So we leave behind

that place far abroad
where sailors gang to fish for cod,

These lands we have been visiting are referred to by custom as "The Maritimes." Canada is maritime on three sides and it was to the maritime province on the west that we next travelled. British Columbia is the only Western maritime province. We in the Prairies speak of going to "The Coast" when we are thinking of that area of B.C. in which a good deal of its population is concentrated — the Fraser Valley and the Vancouver-Victoria area. Inland in its mountain valleys many people live but there are no large centers of population, apart from the maritime region.

For many years the Rocky Mountains were a barrier between what was called British Columbia and the rest of

Alberta Govt. Photo

The city of Calgary

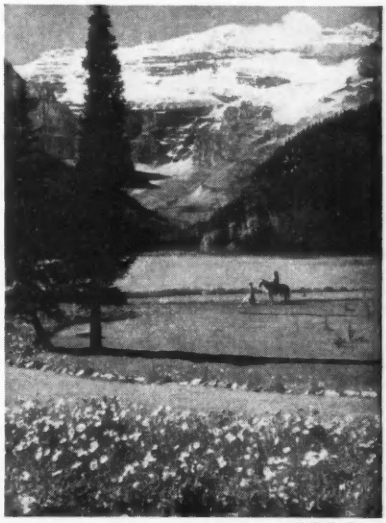
the Dominion. This was really only the small southwestern portion of the province. Today to the east and north much activity has developed. This, together with air travel, has rendered the Rocky Mountains obsolete so far as a barrier is concerned. B.C. used to look south for neighborly associations. Now she can look east.

Geographically you would remember British Columbia because of its north-south characteristics. Its mountain ranges, its valleys, its rivers, its lakes are all arranged in a north-south pattern. The next time you fly to Vancouver take note of this and as you pass into "the West beyond the West"[10] perhaps you can say with George Brown, "British Columbia, the land of golden opportunities."[11]

Alberta,
In token of the love which thou has shown
For this wide land of freedom, I have named
A province vast, for its beauty famed,
By thy dear name to be hereafter known.[12]

The Alberta latitude is from 49° to 60°, its longitude from 110° to 120°. Alberta has prairies, parklands and forests, it has mountains, foot-hills and plains. You have often heard of its resources and its potentialities. You should know that its climate is delightful and that sunshine is its trademark. Most important of all you must know that this is a free land where honest people of any race or creed may find a home. This freedom requires from each one of us eternal vigilance to protect those things which are part of the British way of life.

Our neighbor to the east gets its name from the mighty river system which crosses its territory. For years this river was the high way to the west. The Saskatchewan, or Kissaskatchewan, as Butler[13] calls it, is an Indian word meaning "rapid flowing river." This rapid river stretches from the Rocky Mountains to Lake Winnipeg



C.P.R. Photo

Lake Louise

Civic Auditorium, Winnipeg

and is as much a part of the history of the Canadian West as is the buffalo or the fur trade.

The origin of place names is always interesting. The story is that a traveller fixed his cart with the help of a jaw bone of a moose, while travelling in the vicinity of the city that now bears the name of Moose Jaw. The story does not tell how a moose got down into buffalo country. This part of Canada has been referred to as, "the most magnificent expanse of virgin soil that remains unsubdued on the face of the earth."[14]

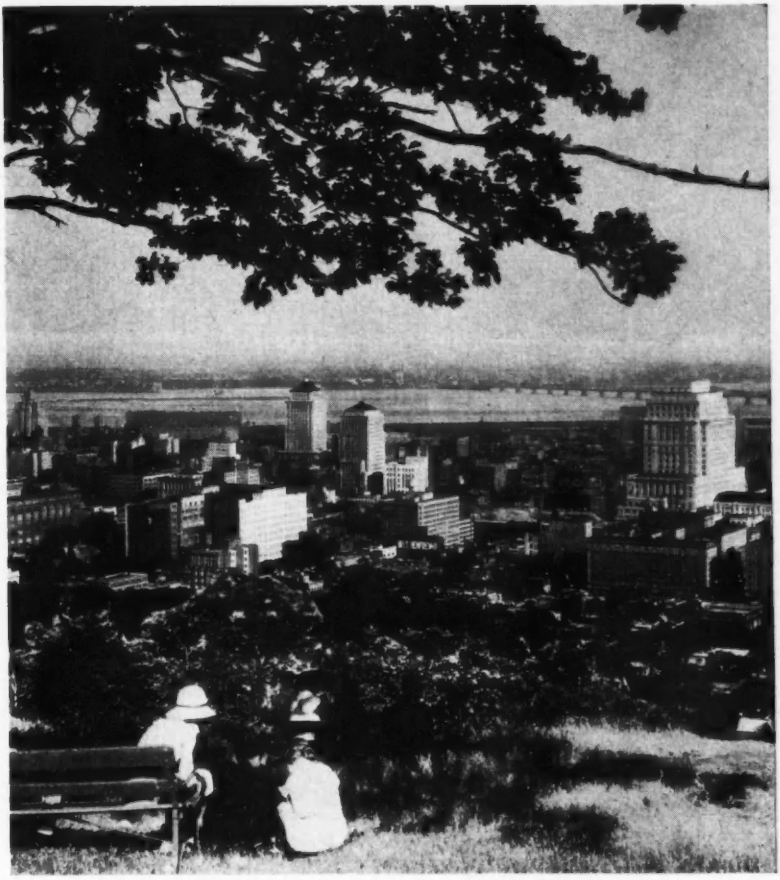
I drove from Regina to Moose Jaw over country as flat as a table. It was this land which caused the poet to exclaim, "The unshorn fields, boundless and beautiful, for which the speech of England has no name. The Prairies."[15] One cannot help but marvel at the fortitude of our ancestors who tramped across those plains at the tail-end of a Red River cart. This is the great wheat land where fortunes depend on nature's supply of moisture.

To the south of the city of Moose Jaw is a most modern hospital of some 400 beds. It is beautifully equipped, well organized and filled to overflowing with mentally and physically backward children. The inmates of this hospital get the best care modern science can give them and yet the most optimistic outlook is that less than 5 per cent will ever be able to look after themselves even with supervision.

May I again mention this great river of the prairies. Homeward bound we saw it from the air, the South Saskatchewan and Saskatoon, the North Saskatchewan and Prince Albert and North Battleford, modern cities situated where the buffalo used to stop to drink. Just west of North Battleford in my imagination I saw Simpson and his retinue paddling upstream to Fort Edmonton. Then in the words of Tennyson "I dipt into the future far as human eye could see, Saw the visions of the world and all the wonders that would be."[16] No wonder Shakespeare says of us, "we are such stuff as dreams are made of."[17]

The Prairie provinces are known to all Canadians. Manitoba was referred to as The Prairie Province by Hamilton in 1876.[18] With the formation of the other two provinces in 1906 they were included in this term. Manitoba is the smallest of the three but in spite of this and its central location it boasts a seaport! It resembles British Columbia in one respect, namely, that a good deal of its population is found in the southern part of the province.

Winnipeg is Manitoba's only large city. It used to be called "The Gateway to The West," and it still is in many respects, other towns also call themselves gateways. The junction of the Red and the Assiniboine Rivers takes place in the heart of the city. This adds beauty to the place even if there is some danger of floods at times.



Montreal as seen from Mount Royal

I never approach Winnipeg from any direction without looking for the turrets made famous by Whittier's poem which I recite to myself.

Out and in the river is winding
The links of its long red chain.
Through belts of dusky pineland
And gusty leagues of plain.
Only at times, a smoke wreath
With the drifting cloud-rack joins —
The smoke of the hunting lodges
Of the wild Assinaboines.
Is it the clang of the wild geese?
Is it the Indian's yell?
That lends to the voice of the north wind
The tones of a far-off bell?
The voyageur smiles as he listens
To the sound that grows apace;
Well he knows the vesper ringing
Of the bells of St. Boniface.
The bells of the Roman Mission,
That call from their turrets twain,
To the boatman on the river,
To the hunter on the plain.[19]

We left for home by air on a pleasant afternoon. By the time we had reached Portage La Prairie we were 14,000 feet in the air and there below us was the winding Assinaboine. Northward was Lake Manitoba with the point of land projecting into the south west margin of the lake. I could see the famous prairie marshes, the home of countless Canvasback and other ducks of international fame. Manitoba dropped behind, Saskatchewan was below us and Alberta just ahead and again the thought, "This is Canada" came to my mind.

The winter was to pass before we

Parliament Bldgs., Ottawa

made calls on the two remaining provinces, Quebec and Ontario. *Chez-nous* in Quebec was at Ste. Adele-en-haut forty miles north of Montreal. We refreshed old memories for a few hours in that old city on the Isle of Montreal. We were travelling by car and had the freedom of time and place associated with this means of travelling. In the late afternoon we entered the Laurentians. I thought again of the suddenness with which one moves from plain to hills in this area.

Ste. Adele is a beautiful spot in this land of lakes and streams, this land of two languages, two cultures, two traditions. "Quebec remained British because it was French."[20] After a pleasant three days we drove to Ottawa along the north bank of the river of the same name. You have heard of the Gatineau Hills and the Gatineau River, both famous in stories historical and otherwise. You have heard of the land of Maria Chapdelaine and of Champlain. Gaspe and Anticosti you have marked on your maps, Montmorency Falls and the Plains of Abraham have invaded your history books. This was the land we were in, this was Quebec. Mathew Arnold said, "Quebec is the most interesting thing by much that I have seen on this continent."[21]

Quebec differs from all other provinces of Canada in the fact that here the two official languages are always recognized, French and English appearing everywhere. In the years to come when there is one official language for the whole world this will not matter. At the present time bi-lingualism is an asset and for the sake of harmony should be more universal than it is.

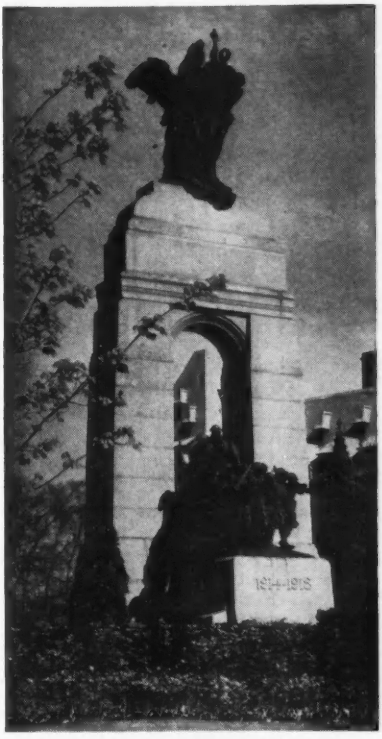
We crossed the bridge from Hull to Ottawa and drove through what was once By-town but is now Ottawa, our Federal Capital. In passing the Parliament Buildings one would hope that here might be the symbol of the Canadian way of life — Peace as suggested by the Tower and solidarity as evidenced by the rocks upon which the buildings rest. After a night of rest we drove on to Toronto, going by way of Peterborough, through the lake country. It was rather early in the morning and for a time we had the road to ourselves. The leaves were just coming out and the early spring flowers were along the roadside. It was all very nice, very quiet and very refreshing.

Dorothy Duncan has said of Ontario — "Ontario is a state of mind, bounded on the east by a foreign language, on the north by wilderness, on the west by the hungry prairies, and on the south by another country."[22] Our travels would lead us to believe that Dorothy Duncan might be clever with words but not too accurate as to observation.

In telling of this province some of our descriptive adjectives will again have to be in the superlative degree. Ontario has the largest population of any of the provinces. It must have two of the largest counties in the world since it would seem that most of the people living in the three prairie provinces come from either the County of Huron or the County of Bruce. The Duke of Wellington once said, "If you lose Upper Canada you will lose all your colonies, and if you lose them you might as well lose London."[23] Ontario has apparently been well thought of for some time.

Ontario has the Great Lakes. There is no other water system like them anywhere else in the world and the St. Lawrence Seaway will bring Liverpool to our doors. Large ocean ships will sail half-way across a continent and Champlain's dream of a route to the Western Sea is more than half realized. Dreams do, sometimes, come true.

We enjoyed our stay in Ontario, we had a pleasant time with its people. It had been a good year, a year full of pleasant things and kind thoughts, a year of many meetings and much travelling, a year of new names, new faces, new friends. Thus is life made worthwhile.



Canada's Memorial

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Myocardial Infarction

SISTER RITA MCDERMID, R.H.S.J.

MR. CARSON, A 64-YEAR-OLD MAN, was admitted complaining of having had an attack of severe chest pain. A diagnosis of acute myocardial infarction was made. The myocardial infarction, that is, the death of an area of heart muscle was due to a coronary thrombosis which caused an ischemia. This in turn was really a complication of arteriosclerosis which had been gradually developing.

Arteriosclerosis or "hardening of the arteries" of the heart is associated with aging. The presence of diabetes, high blood pressure, or excessive fat in the blood probably accelerates its development. Eventually a clot forms in a narrowed artery, shutting off the flow of blood to the area of the heart supplied by that artery. This is termed a *coronary thrombosis.*

The area of the heart deprived of its blood supply undergoes a process of necrosis, termed *myocardial infarction,* in which the cells die due to lack of oxygen and nutritive material. The agonizing chest pain is probably due to the lack of oxygen in the damaged area. The dead area of muscle is at first very soft. Later the infarct is replaced by fibrous tissue if the patient survives. This fibrous tissue is weaker than heart muscle and the wall of the heart may bulge at the site of the scar.

For the first few weeks after the infarction the patient's life is in jeopardy. During this period the damaged heart may rupture causing instant death or the patient may go into shock because the injured heart cannot exert enough force to maintain the pressure level that is essential for an adequate blood flow. Furthermore, the normal propagation of the electrical impulses which initiate each contraction may be disturbed. This results in the establishment of dangerous rhythms within the heart.

Typically the pain of myocardial infarction is a severe and crushing sensation in the middle of the chest which lasts for hours. The pain is not relieved by nitroglycerine and requires large doses of morphine to make the agony bearable. Associated with the pain are evidences of shock — pallor, drop in blood pressure, feeble heart sounds, weak pulse volume and sweating. The patient may die suddenly at the onset of the condition before he experiences much pain, or within a few moments. More often however, the pain ceases after a few hours and the patient revives from shock.

Medical History

Four days previous to his admission Mr. Carson experienced pain across the front of his chest. This pain came on gradually and was a steady, tight ache which recurred intermittently for three days. He was not troubled by nausea or vomiting and did not suffer from dyspnea. On the day of his admission the chest pain became more severe and continuous. It was like a crushing sensation in the substernal area which did not radiate.

Sister McDermid, a senior student in St. Joseph's School of Nursing, Hôtel Dieu Hospital, Kingston was awarded the first prize of $25 in the competition sponsored by the Macmillan Company of Canada.

He was visited at his home by the doctor and received an intramuscular injection of 100 mgm. of Demerol to relieve his pain. In the evening he was admitted to hospital by stretcher and helped to bed with as little exertion as possible. His chest pain had subsided and there were no signs of shock. His temperature, pulse and respirations were recorded as 97°-84-20. His pulse was regular and of good volume. The blood pressure reading was 120/80. His color was fairly good and he rested quietly, dozing at intervals. There was no dyspnea or cyanosis and the administration of oxygen did not appear to be indicated.

Clinical Investigation

A medical history was taken and a physical examination was performed by the intern on the morning following admission.

Some 20 years before Mr. Carson had been operated on for stomach ulcers and since then had not been troubled with gastric disturbances.

Further surgery was performed several months ago when a large growth was removed from the colon. The pathologist's report on the tissue removed indicated an infiltrating adenocarcinoma extending into the muscle coat but not to the serosa. Sections of lymph nodes removed from the area showed reactive hyperplasia but no evidence of secondary tumor. Mr. Carson made an uneventful recovery from this operation. On his discharge from hospital, he continued his convalescence at home and had not yet resumed any active duties when the episode of chest pain occurred necessitating his readmission to hospital.

Physical examination revealed that the respiratory system was normal. The rhythm of the heart beat was irregular with what appeared to be an extra systole after every alternate normal beat. There was no evidence of heart failure or edema. Palpation failed to reveal any mass or tenderness in the abdomen and the liver was not enlarged.

Social History

Mr. Carson had served with the Canadian Army overseas during World War I. He received injuries in his left foot while on active duty but suffered no permanent disability. In recent years he was employed as a civil servant and enjoyed comparative comfort and security. Following his bowel operation he had been living a quiet and inactive life while trying to regain his strength.

His home life was happy. He was surrounded by affection from both his family and his many friends. His amiable disposition and likeable nature endeared him to many and in his quiet way he exerted considerable influence over those around him.

Mr. Carson was a religious man and derived great comfort and strength from his convictions. He was accustomed to temperance in eating and drinking and enjoyed living quietly. His hobbies included gardening, particularly the cultivation of flowers, and reading. Baseball, hockey and other sports gave him passive enjoyment and he followed these activities with keen interest.

Financial worries did not present a problem since his hospital expenses were covered by insurance. He and his wife could live comfortably in the future on the pension he received from the government. He asked very little of life and only wished to recover his health sufficiently so that he could return home and quietly live out the rest of his days in the enjoyment of his home and family.

Laboratory Results

The results of urinalysis were fairly normal. The alkaline reaction instead of the normal acid reaction was not of any great significance. The presence of a trace of acetone showed that there was a small amount of ketone bodies in the urine as the result of a slight metabolic disturbance. The presence of a few white blood cells in the urine may be considered normal.

Mr. Carson's hemoglobin was 102 per cent. This was within the normal limits of 90-105 per cent for a man.

An electrocardiogram was done at the bedside. This test is a visual representation of the electrical activity of the heart and is a valuable diagnostic aid in determining the presence and extent of heart damage. The interpretation of the results showed that an anteroseptal myocardial infarction had occurred. This electrocardiogram was

Test	*Result*	*Normal*	*Significance*
White Blood Count	11,750	5000-9000/cu.mm.	The white blood cells were slightly increased showing that there was a slight leucocytosis. There is normally a leucocytosis present the day following a myocardial infarction resulting from the absorption of necrotic material from the infarct.
Differential White Blood Count	Lymphocytes 19% Neutrophiles 75% Stab Cells 3% Monocytes 3% Eosinophiles Basophiles	20 to 25% 65 to 75% none 3 to 8% 2 to 5% ½ to 1%	The differential white blood count revealed that the percentage of neutrophiles was slightly increased — neutrophiles 75% plus stab cells 3% giving a total of 78% as compared to the normal range of 65 to 75%. This finding coincided with the slight leucocytosis present.
Sedimentation Rate	10 mm. in 1 hr.	0-9 mm. in 1 hr. (Westergren method)	There is usually an increase in the sedimentation rate following a myocardial infarction. The sedimentation rate then gradually returns to normal and is often used as a means of determining the progress of healing of the injured heart muscle. Mr. Carson's sedimentation rate of 10 did not show any elevation at the time that the test was taken.
Prothrombin Time	67%	80 to 100%	Mr. Carson had already received 200 mg. of Danilone — an anticoagulant — when this test was performed. The result was therefore below the normal value and indicated that the Danilone had already begun to act in decreasing the rate at which the clotting of the blood occurs.

compared with one done three years previously, and reported as normal. Subsequent electrocardiograms were done and marked improvement was noted at first, but changes were minor at later dates.

Treatment and Nursing Care

From the first moment of his admission to hospital Mr. Carson became the centre of a concentrated medical effort which had but one end in view — his ultimate recovery. Relief from pain, rest and reassurance formed the basis of all treatments and nursing care.

The first 24 hours following the attack were the most critical ones. During this time attention was mainly directed to keeping Mr. Carson comfortable and free from pain, with a minimum of disturbance and exertion. An injection of 100 mg. of Demerol was ordered intramuscularly for the relief of chest pain whenever necessary. Demerol is a synthetic substitute for morphine and has an analgesic action that approaches morphine in effectiveness.

Complete bed rest was ordered meaning absolutely no exertion and an abundance of sleep. A damaged heart needs to be put at rest as much as possible in order that healing may take place. This is accomplished by limiting physical activity and thus decreasing the load of work which is normally placed upon the heart.

Mr. Carson had to be fed, washed, lifted and turned in bed, helped on and off of the bed-pan, so that he would be spared any exertion. Reassurance was necessary in order to make this form of treatment agreeable to him. The experience of being a helpless invalid confined to total inactivity was hard for Mr. Carson to accept. With explanation and encouragement he cooperated wonderfully well and half the battle was won. This ready docility continued to help him throughout the long weeks of recovery.

The observation of symptoms was extremely important. This included his general appearance — his color, whether cyanotic or normal, his expression, whether anxious, pained or relaxed. He was observed for signs of dyspnea or coughing. His blood pressure was checked twice daily and oftener as directed. Temperature, pulse and respirations were taken at four-hour intervals, and in addition to the pulse rate, the volume and other irregularities were recorded.

After the critical 24-hour period following the attack the nursing care was mainly aimed at the achievement of complete physical and mental rest. This meant that nursing care had to be thoughtfully planned and executed by grouping treatments, avoiding noise, jolting and disturbances and by anticipating needs.

A cheerful approach was the best ally in dispelling the anxiety which is common to all those affected with heart disease. Mr. Carson responded readily to cheerfulness and optimism.

A complete bed bath was given each morning. This was a simple but effective means of promoting comfort and stimulating the circulation. Particular care was given to the areas most likely to develop decubitus ulcers — the buttocks and the bony prominences.

The doctor ordered a light diet which consisted of easily digested food in small quantities. This avoided overburdening the digestive system with resultant strain on the heart. Mr. Carson was accustomed to smoking at least one package of cigarettes a day, but at the insistence of the doctor he consented to forego this pleasure. Smoking is believed to have an effect on the circulatory system whereby there is a rise in blood pressure and the burden on the heart is increased.

Visitors were restricted to his family. They were very cooperative and understanding in avoiding all worrisome topics of conversation.

Medications

Neurotrasentin tablets were ordered four times daily as an aid to rest and relaxation. Neurotrasentin contains trasentin, which has an antispasmodic action.

Phenobarbital gr. ¼, a barbiturate, was given in small doses to reduce nervous excitability and control the fear and anxiety that intensify the distress of myocardial infarction.

Nembutal sodium gr. 1½ was ordered every evening at bedtime if necessary. Nembutal, or pentobarbital sodium is used for its hypnotic effect. However, Mr. Carson found that he could get along very well without this nightly sedation and slept soundly.

The first day after admission, *anticoagulant therapy* was begun with the administration of 200 mg. of Danilone. Danilone is a synthetic anticoagulant which lowers the concentration of thrombin in the blood and thus lowers the prothrombin activity. It is used prophylactically in the treatment of myocardial infarction to prevent the formation of further intravascular blood clots. In this way the complications of peripheral venous thrombosis and pulmonary embolism can usually be avoided. The continued dosage of Danilone is adjusted as the prothrombin time indicates.

The results of the prothrombin time for the first few days were as follows:

Date	*Patient*	*Control*	*Prothrombin Content*
1st day	18 sec.	15 sec.	67 per cent
2nd day	24 sec.	14 sec.	30 per cent

The dosage of Danilone was prescribed each morning depending on the results of the prothrombin time as determined on the morning of that day. The usual dosage at first was 100, 150 or 175 mg. to maintain the prothrombin content between 20 and 30 per cent.

After the first day, the prothrombin content dropped to 11.5 per cent and the following day it was less than 10 per cent. Danilone was discontinued for a few days until the level was 46 per cent. It was then administered in reduced dosages of 50 to 100 mg. daily.

During the course of anticoagulant therapy Mr. Carson was observed closely for any signs of hemorrhage, such as: bleeding from the gums; purplish, hemorrhagic areas under the skin, or hematuria. Even when the prothrombin content dropped to less than 10 per cent Mr. Carson did not show any hemorrhagic tendencies.

A laxative of *milk of magnesia with cascara* was ordered as required to prevent constipation and straining at stool. The effort of trying to have a bowel movement may place such a strain on the heart that it might even prove fatal.

Mr. Carson had a slight rise in tem-

perature on his first day post-admission, from 97° to 99.4°. On the second day his temperature rose to 100.4° but on the third day it returned to normal. Fever usually follows in 12 to 24 hours after an attack of myocardial infarction and may vary from 100.4° to 102°F. by rectum, for a few days. The fever is caused by tissue necrosis in the affected heart muscle.

Mr. Carson's pulse was 84 on admission and of good volume. It was 112 on the second day, then gradually, over a period of several days, returned to a level of about 84.

One week after admission, in early morning, Mr. Carson experienced pain in the cardiac region and left upper arm but failed to report this. The pain subsided some two hours later and was not mentioned until mid-morning. His pulse was then 84 and regular. The blood pressure reading was 140/80. At 1:30 P.M. 50 mg. of Demerol was given for the relief of slight chest pain. This was the only occasion on which Mr. Carson experienced chest pain during his hospitalization. An electrocardiogram showed that there had been considerable improvement since the last one.

A daily dose of 500 mg. of *Redoxon* — an injectable form of vitamin C was begun a week after admission and continued for three weeks. A deficiency of vitamin C may result in delay in healing of wounds or it may actually cause a breakdown in the healing process. Vitamin C was therefore important to promote healing of the damaged heart muscle.

After two weeks on complete bed rest, Mr. Carson was allowed to do small things for himself. He was able to sit up in bed, supported with pillows and with the head of the bed elevated. He enjoyed feeding himself and was able to do such things as clean his teeth, shave, and even some light reading.

Three weeks post-admission Mr. Carson was allowed to sit out of bed in a comfortable armchair for about 20 minutes. He was observed closely for signs of fatigue, irregular pulse or chest pain. The effort of being out of bed tired him considerably but had a good psychological effect in making him confident of his progress. For the next few days he continued to spend about 20 minutes each day sitting up in a chair. As the next step he was given bathroom privileges provided he had the assistance of an orderly.

Progress continued without any setbacks or reversals until the fourth week when Mr. Carson experienced an attack of weakness while in the bathroom. His pulse became rapid and irregular. He was assisted back to bed and in a short while his pulse became regular and slower and he rested comfortably.

Following this episode some of his medications were changed. Neurotrasentin was discontinued and Equanil tablets, 400 mg., were ordered three times a day. *Equanil* is one of the tranquillizing drugs and is described as having an anti-anxiety factor with muscle relaxing properties. Redoxon was discontinued and Demerol 25 mg. was ordered when necessary for any further pain. Mr. Carson was ordered to remain in bed for a few days before trying to sit up again.

Complications began to develop in the form of an intermittent fever which persisted for about two weeks. During this time Mr. Carson's temperature fluctuated throughout the day ranging between normal and 102.8°F. accompanied at times by chills and profuse diaphoresis. He had no complaint of pain or cough. His chest seemed clear and there was no apparent evidence of thromboembolytic activity.

Treatment during this time included forced fluids and tepid sponges when the temperature persisted at about 102°F. Frequent sponge baths and backrubs were necessary due to the profuse diaphoresis. Psychotherapy became increasingly important in an effort to maintain Mr. Carson's morale and prevent discouragement and depression. His blood pressure fluctuated with variations from about 120/80 to as low as 80/50. Readings were taken every two hours at this time.

Dicrysticin 1 cc. was prescribed intramuscularly twice daily. Dicrysticin is an antibiotic containing procaine penicillin G with potassium penicillin G, streptomycin sulphate and dihydrostreptomycin sulphate. It is effective against a wide variety of gram positive and gram negative organisms. Two tablets of aspirin phenacetin compound with codeine gr. ¼ were ordered every

four hours to exert an antipyretic action. This medication was continued for several days.

The dicrysticin was discontinued in favor of chloromycetin 250 mg., every four hours. *Chloromycetin* is a wide spectrum antibiotic which is capable of antibacterial activity against a large number of gram positive and gram negative organisms and against a number of rickettsial and virus infections.

Neovacagen tablets were ordered four times a day for two days. *Neovacagen* contains antihistaminics as well as vaccine against staphylococcal, pneumococcal, streptococcal infections and hemophilus influenza.

Results of further tests showed that there was a slight leucocytosis and that the neutrophiles were considerably increased due to some infectious or inflammatory condition. The sedimentation rate of 52 mm. showed a marked increase over the level of 10 mm. on admission.

A chest x-ray showed only a few speckled calcifications in the right lower chest without any evidence of any acute process in the lung field. The cardiologist felt that Mr. Carson had a viral infection from which he seemed to be recovering well. A repeat chest x-ray showed soft, blotchy shadows in the lung field but no overt pneumonic consolidation was observed.

The chloromycetin was discontinued since Mr. Carson had begun to have frequent, loose bowel movements. *Kaopectate,* a mixture of kaolin and pectin, was prescribed four times a day to control the diarrhea.

Mr. Carson had a slight cough a few days later for which the doctor prescribed *Cheracol* two drams every four hours. This is a sedative cough mixture containing codeine, chloroform and ammonium chloride.

Further laboratory investigation included a urine culture and a blood culture in an attempt to discover any infectious agents in the body. If the fluctuations in temperature had been due to a cystitis this would have been discovered in the urine culture. The result of this test was negative. The blood culture was done to rule out the possibility of septicemia. The blood culture was sterile.

Tetracycline phosphate complex, 250 mg. which is a broad spectrum antibiotic was prescribed four times a day. This medication was continued for five days. By this time the fever had almost completely subsided. There were no further deviations from the normal temperature. Mr. Carson gained strength slowly.

Digitoxin was prescribed in an effort to improve the efficiency of the heart. The dosage was 0.4 mg. daily for three days, followed by 0.1 mg. daily. Digitoxin stimulates the heart muscle causing an increased force of systolic contraction, improved tone and increased irritability of the heart muscle. Mr. Carson stated that he felt decidedly better after this medication was begun.

Conclusion

In a recovery free from complications, a firm scar is formed at the site of the myocardial infarction in 5-6 weeks. During treatment in hospital the patient's activity is gradually increased and during his last week the patient is up walking about in his room. After discharge convalescence is continued at home and the duration of the rest after acute myocardial infection should be three months or longer.

Mr. Carson did not expect to become very active at home. He was quite content to plan to live quietly following a routine that includes adequate rest, a light diet, suitable recreation and the avoidance of all excitement and stress.

He seemed to realize even without being told that he would have to continue to exercise care and patience and respect his limitations.

His wife was extremely cooperative throughout his illness and assisted in keeping up his morale. It was equally important to give her every consideration and encouragement.

Knowledge is of two kinds: we know a subject ourselves, or we know where we can find information about it.

— Samuel Johnson

The nurses of Ecuador recently organized their National Association of Nurses, thus adding to the number of national nurses' associations.

Esophageal Diverticulum

BERNICE MYERS

MRS COLE was admitted with the diagnosis of esophageal diverticulum. A native of Scotland, she came to Canada shortly after her marriage and her life had been devoted to her husband and five children. Not until recently had she suffered from any illness other than the usual childhood diseases. A few years ago her husband died, and Mrs. Cole went to live with one of her children. Following this, she first noticed the early symptom of her condition — a slight discomfort in the sternal region after eating. Occasionally she vomited a substance that she described as "frothy mucus."

These symptoms, not being too severe, went on for two years without any medical attention. Eventually her condition was diagnosed as esophageal diverticulum and she was advised to eat only soft foods, consisting mainly of canned baby food. During the year her symptoms grew worse, but no further treatment was carried out. Mrs. Cole started loosing weight rapidly and suffered from severe pain in the region of the diverticulum. She often became nauseated after eating. One week prior to admission to hospital she was unable to tolerate any nourishment, and her general health was poor.

Mrs. Cole was about five feet one, very neat in appearance, and she had a pleasing personality. She seemed somewhat apprehensive about her condition and admission to hospital. She stated that she had lost 50 pounds in the last year, and had been confined to bed many days. She was weak and pale and needed assistance in getting undressed.

Since companionship is a means of diversion Mrs. Cole was placed in a four-bed ward with ladies of her own age, who had non-infectious diseases. This was to help eliminate the chance of cross infection, which was greater due to her age and prolonged illness. She had only been hospitalized once before, for a short period. She needed help and understanding in order to become adjusted to her new environment. Throughout this period, she received great enjoyment from talking with and listening to her room-mates.

In caring for Mrs. Cole we had to develop an understanding of her way of thinking, and we noted the amount of support she needed and expected from the nursing staff. An elderly person wants to be treated as a person, an adult, an individual. Maintaining the individuality of a patient is important in giving good nursing care. The aged especially want to think, to talk, to be listened to, and most of all not to be pushed around.

Medical Treatment

Mrs. Cole's treatment began with continuous 5 per cent glucose in normal saline intravenously, nothing by mouth, and bed rest. Since her mind was very clear and alert, she had no difficulty in understanding the explanation relevant to this. To relieve the dryness in her mouth she was encouraged to use mouth washes frequently. Brushing her dentures three or four times a day added to her comfort. During this stage of treatment she stated that she felt much better and she did not have vomiting or pain. It was also apparent that she was regaining some of her strength.

Maintaining normal physiological function is another important factor in the care of any patient. With the inconvenience of an intravenous running Mrs. Cole favored one position and had to be reminded to move about to relieve the pressure on her buttocks and to increase respiratory activity. Bed rest limited the range of movement in her joints — a matter of concern in the care of the elderly. To help correct this, Mrs. Cole was assisted in putting her limbs through a full range of motion when she was bathed each day. This, as well as proper positioning and a foot-board helped to maintain body

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Miss Myers, a senior student at Sarnia General Hospital when this study was written was awarded a first prize of $25 in the Macmillan Award competition.

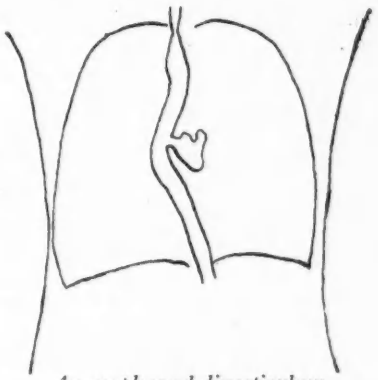
alignment. A record of her intake and output was kept to help in maintaining fluid balance.

When admitted Mrs. Cole was aware of the fact that she had an obstruction in the passage from her mouth to her stomach. It was expected that she would ask many questions about what would, or might, be done for her. Before any questions had arisen her doctor was contacted and while discussing her condition, he indicated that she would probably be having surgery and that he would appreciate it if the nurses would help to explain to her that she would be left with a permanent gastrostomy.

Anxiety is a state of dread or apprehension with respect to some anticipated danger. At the first mention of surgery it was evident that Mrs. Cole was afraid of its outcome, but did not admit it. Instead, she said immediately that it was out of the question; that she did not have enough money to pay for an operation. Her financial affairs were discussed with her son and it was found that she had adequate money. This lead to the belief that she was rationalizing and substituting financial difficulties for the real cause of her anxiety.

Although Mrs. Cole did not ask many questions, she was told about the anesthetic in simple terms and the operation was explained to her. The surgeon planned to make an opening into her stomach and to position a small rubber tube inside which would lead to the exterior surface. She would be fed through this tube. Her diet would consist of a variety of pureed foods corresponding to a regular diet. By this means, she would obtain the nutrients necessary to promote good health.

Mrs. Cole's questions in regard to her operation dealt mainly with her after-care. It was only fair to answer her questions truthfully. In doing so her confidence was gained and a better rapport established. As time passed Mrs. Cole still showed signs of anxiety, but this was perfectly normal. She seemed to be relieved by continued reassurance and by allowing her to talk. She turned to her family and religion for much support. Her strong religious faith and her will to live were important factors in her recovery.



An esophageal diverticulum

The results of a gastrointestinal series of x-rays indicated the obstruction was almost complete. Mrs. Cole was booked for a gastrostomy. A short while after receiving an injection of Demerol 50 mgm. and atropine sulphate gr. 1/150 Mrs. Cole went to the operating room.

Postoperative Care

Following the operation the doctor told her nurses that the gastrostomy had been performed successfully with no apparent complications. When Mrs. Cole awoke in the recovery room she asked immediately about the operation and her chances for good health. In reply, she was told the surgeon's exact words.

By the time she had returned to her room she was suffering from the usual postoperative pain. This was relieved by medication. As had been done every night to protect the patient from any injury, the bed sides were put up. She was observed for signs and symptoms of shock or hemorrhage. Her blood pressure remained stable at 100/50, which corresponded well to the preoperative reading. Her color was good, her pulse regular and strong. Mrs. Cole had no nausea or vomiting which contributed to good recovery. As a comfort measure, to aid in circulation, and to prevent hypostatic pneumonia she was turned frequently. Massaging her back helped her to relax and get the rest she needed.

The next morning her nurses' conversation with Mrs. Cole indicated that she had adjusted well to surgery. Because of her positive attitude it was felt that her rehabilitation should con-

tinue at once for her welfare in the future.

Rehabilitation

"Rehabilitation means the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness, of which they are capable."[1] The aims in rehabilitating Mrs. Cole were, first of all to teach in simple terms the care and function of a gastrostomy; to promote the social and emotional adjustment of this elderly person to her gastrostomy; to make it possible for her to find companionship and create a satisfactory environment which would give her a sense of security; to make it possible for her to function at the maximum of her ability, thus giving her that necessary feeling of independence that she wanted.

Mrs. Cole and her nurses had talked over the advantages and disadvantages of a nursing home. She recognized the fact that she could probably be happy living in one, but felt that it would be more satisfactory to continue staying with her son, if she could care for herself. She was told that it was hoped that she would be able to do her own feedings by the time she left hospital. Arrangements were made for her family to come in to be taught how to prepare her meals. To Mrs. Cole, this seemed the sensible answer to her problem.

When her gastrostomy tube was first put into use she felt relieved by its success and usefulness. The first day postoperatively, she was subject to nausea and was started on 5 per cent glucose in normal saline continuous drip per gastrostomy tube. She needed some help to understand the procedure and why the solution was given continuously. By this means, Mrs. Cole received 2500 cc. of fluid. That same night the drip was discontinued, and with the aid of an injection of Sparine 50 mgm., the patient slept soundly.

The following day she was given skim milk 1000 cc. Over a period of three days her feedings increased from a high protein, high caloric mixture to a regular diet prepared by means of a blender. At the beginning, the feedings were limited to 200 cc., and were given every two hours, day and night. The reasoning behind this was to administer only the amount that her stomach could tolerate comfortably at one time, and to provide the extra nourishment required due to her prolonged illness.

Mrs. Cole's hemoglobin had dropped considerably. To help build it up an iron preparation was added to the feedings, three times a day. In this same way, Magnolax was given on two occasions to aid in maintaining normal bowel function.

On the whole these feedings proved satisfactory, although on the second and third day postoperatively they prevented Mrs. Cole from sleeping uninterruptedly at night. This disadvantage was considered in planning her nursing care. During the day all procedures possible were carried out at one time so that she could sleep at regular periods.

At this point Mrs. Cole's main problem was in accepting the fact that she would never again be able to sit down and enjoy a meal with her family and friends. She had always eaten small quantities but she enjoyed her food and liked to go out for dinner occasionally. This was realized before she had her surgery and her nurses tried to arrange their work so that they could be with her while the other patients were eating. The first day the nurse stayed with her, Mrs. Cole indicated that she was depending on her to do the same each day. It was felt that she might become too dependent so on the second day attention was limited to staying with her while meals were being served. Gradually she learned to accept her abnormality, and to realize that there were other things in life as important as eating. With permission from the doctor, she was given hard candies to suck which satisfied her sense of taste and relieved the dryness in her mouth. As time went on Mrs. Cole felt very proud to think that she had overcome another problem with much less difficulty than she had anticipated.

Although she had accepted this very well, it was necessary to protect her somewhat from the temptation to eat. In the morning her bath was started while the others were having breakfast. At lunch hour, before she was able to get up, she was assisted in doing exercises to help regain her strength. This was successful as a means of di-

version and helped prepare her for the day that she would get out of bed.

By the fourth day postoperatively Mrs. Cole was receiving her feedings every four hours, starting at 10:00 A.M. and ending at 10:00 P.M. and consisting of 300 cc. each time. This was the equivalent of the 2000-calorie diet that she would be ordered on discharge. With these regular feeding periods it was possible to establish a routine for her which was followed for the remainder of her stay in hospital, and which included gradually increased activity each day. Most elderly people like a routine and Mrs. Cole was no exception.

Teaching her to feed herself properly was another point stressed in her care. It was explained to her what her feedings consisted of, how they were prepared and the actual procedure itself. Her son and daughter-in-law came to the hospital to observe the gastrostomy feeding.

The family had a good understanding of what constituted a proper diet but since Mrs. Cole would require extra proteins and vitamins, they were given a diet sheet and pamphlets as reference. The use of the blender in preparing the feedings was demonstrated and it was emphasized that the mixture had to be thin in order to run through the tube freely. The family was anxious to learn, and appreciated the time spent with them. The doctor and dietitian helped a great deal in this phase of nursing care.

The care of the tube itself had to be explained. This consisted of sponging it with an antiseptic solution, before each feeding and removal once a month for sterilization by boiling. This routine in addition to cleansing, allowed for observation and correction of any abnormality.

Although it was estimated that by the time her discharge day came Mrs. Cole would be able to care for herself, continued professional care might be beneficial to her and her family. The son and his wife were told about the work of the Victorian Order of Nurses, the cost and of what use it could be to them. At that stage they felt that it would not be necessary to have V.O.N. assistance but they were glad to hear that they could contact this agency through their doctor if any problems arose in the future.

As time went on Mrs. Cole liked to watch the preparation of her feedings. Administering the mixture herself seemed to give her the feeling of independence which was so important to her.

Mrs. Cole progressed much more rapidly than had been expected. She regained weight and strength which enabled her to be up and about most of the time. Her entire outlook on life changed after her surgery and she began planning the things she would be able to do when at home. She took a new interest in her church and was happy to think that she could again take part in its activities.

Conclusion

Discharge day had a special meaning to Mrs. Cole. She was not only capable of caring for herself, but she was able to do things for others. From all reports Mrs. Cole has done very well. She has adjusted herself satisfactorily to her environment and is making the most of life.

It is beyond a doubt that everyone should have time for some special delight, if only five minutes each day to seek out a lovely flower or cloud or a star, or learn a verse or brighten another's dull task. What is the use of such terrible diligence as many tire themselves out with, if they always postpone their exchange of smiles with Beauty and Joy to cling to irksome duties and relations? Unless they admit these fair, fresh, and eternal presences into their lives as they can, they must needs shut themselves out of heaven, and a gray dust settles on all existence. That the sky is brighter than the earth means little unless the earth itself is appreciated and enjoyed. Its beauty loved gives the right to aspire to the radiance of the sunrise and the stars.

—From "My Religion" by Helen Keller, Copyright 1927 by Doubleday & Co., Inc.

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It is by presence of mind in untried emergencies that the native metal of a man is tested. —JAMES RUSSELL LOWELL

The Psychiatrist and the Child

TAYLOR STATTEN, M.D.

BECAUSE of the nature of psychiatric illness in children, the concept of teamwork is an integral part of their treatment. The most common cause for the referral of a child for psychiatric treatment is because he is not getting along well with other people, either outside or inside the family group. Usually some interested person or persons has tried to correct the situation before the child comes to a psychiatrist. For this reason a psychiatrist may find himself involved with a whole group of people concerned with the child's care. This is especially true of children who are in the care of agencies and schools. The greatest number of children coming under examination are school children. Usually the principal and teachers are ready to offer their helpful observations. They may form the nucleus of a team of interested professional workers involved in helping the child and family right from the time of the first referral.

Family Teamwork

Few children coming under the care of a psychiatrist have complaints that are entirely centred outside the family group. It is the rule rather than the exception for the psychiatrist to find that the child is in a family that is having many difficulties. Sometimes, especially at the start of treatment, these difficulties are not recognized by the other members of the family group. The troubled child more often than not is a symptom of a deeper family discord. It is generally safe to assume that the family teamwork has broken down in some way. It is the job of the psychiatrist to ferret out the kind of breakdown that has occurred, to discover how it started and to try to figure out the best and quickest way to build up the morale and spirit of the family team. Here are some of the factors contributing to family breakdown in the more typical cases.

It is a normal human ambition for parents to want healthy babies. A haunting fear of every mother and father is that they may bring into the world a child with a deformity — something that will impede normal growth and development. The first reaction of any mother after birth is to want to examine her baby and to be reassured by her doctor that the child is normal and healthy. The despair and anguish that are felt when this is not the case bring a flood of guilt feelings from all the recesses of the mind. These feelings become focused on the child as the parents search for an explanation. It takes the finest skills of the medical profession and a tremendous belief and strength of character in both parents to be able to adjust to the situation of an infant with a physical abnormality.

A more difficult situation exists when a handicap becomes apparent only slowly as the child develops and where little hope exists for the correction of it. This latter problem exists in those families where a mentally retarded child is found. This condition presents so many problems that, at the present time, the medical profession has only touched the surface very superficially. A tremendous amount of energy and money will have to go into basic research if we are to understand this problem and find solutions to it. Any family with a difficulty of this nature will testify to the effects of the birth of such a child on family integrity, economy and relationships. Any problem in family teamwork developing as a result must be recognized and dealt with in addition to carrying out any corrective medical procedures for the child.

The most common kind of psychiatric problems in children develop in families where there are varying degrees of difficulties existing between the parents. In a study of family mental health certain investigators found that the healthiest family from a mental health standpoint was the one in which

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there was the greatest amount of communication between the various members. The converse was also found to be true. The family with the poorest communication between its members showed poor mental health. The findings of Goldfarb, Bowlby, Spitz and others have proven very conclusively that babies raised in institutions and deprived of adequate mothering during the first year of life will produce personalities so severely distorted that they will always be severe psychiatric problems. Any situation that removes the mother from her baby in early infancy can be considered as a serious breakdown in family teamwork. It is sure to produce serious repercussions in the development of the child's personality.

Those of us who were forced to be away from our young families during the war know of the serious effects of such a separation and the subsequent difficulties in integrating the family. Anna Freud and Dorothy Burlingham have recorded the effect upon small nursery school-aged children of separation from their families as a result of the evacuation of children from the bombed areas in England.

Physical and mental illness can break up the family team if the parents are involved. A parent can be so mentally depressed that, from an emotional standpoint, the situation may be even worse than a separation by distance. Physical illness has its emotional effect on the family as well as its economic consequences. Mental illness of one of the parents, especially when unrecognized and untreated, has a devastating effect upon a child and the family morale. In the families seen by psychiatrists called upon to treat the children, one frequently has to deal with a parent or parents whose mental illness has gradually and unrecognizably created difficulty for the entire family.

Psychiatric Team

Because of the nature of child psychiatric problems a team approach to the difficulties has been established. The basic members of the team are the referring physician, be he a general practitioner or a pediatrician, the psychiatrist, the social worker and the psychologist. The physician has usually known the family for some time and often has attended the child since birth. His knowledge of the growth and development of the child and the interpersonal relationships of the family make him an invaluable source of information. He will continue to care for the child and perhaps the other members of the family when the current problem has faded and the psychiatric treatment has become only an important incident in the life history of the family.

The social worker is trained to investigate and understand the social and economic problems of the family. She knows the resources in the community and what they can offer. She is trained in the technique of casework and has a sound understanding of family and individual mental health. Through the technique of casework, which is an interview method, she is able to deal with the less severe personality difficulties of the parents.

The psychologist is a non-medical, professional person who understands personality development. Through the use of tests of various kinds he can provide information about an individual's intelligence, way of thinking, approach to problem-solving and personality structure. The child psychiatrist makes his diagnosis with the aid of the social worker and psychologist. He develops plans that may involve many other people in a teamwork approach to the problem.

The psychiatrist often decides to work closely with the child in order to develop a deeper understanding of the working of his mind and emotions as he interacts in the family. Treatment may be anything from a few interviews to many years of interviews. The frequency of the interviews will vary from once or twice a year after the initial interview to a daily visit. The average in the Montreal Children's Hospital clinic is once a week at the present time. Younger children reveal their anxieties, fears and conflicts in their play and thus indicate their innermost problems to the psychiatrist.

Teamwork within the Hospital

There are many aspects of teamwork that have developed in the hospital. Probably the most important person to a sick child is the person who is going

to take mother's place when the child comes into hospital. The nurse and the parents form a primary team. They must work in close cooperation to help the child in his separation from his loved ones.

In the M.C.H. department of psychiatry we have a Day Treatment Center for emotionally disturbed preschool children. To the children at this center the nursery school teacher is the temporary mother substitute. She has been especially trained to understand the workings of the minds of these young children. For six or eight hours a week the children are brought into close association with the teacher and through her the child learns to know another adult with different values from those of the parent. The child also sees a psychiatrist, on a weekly basis, who has a deeper insight into the processes of the mind of the child and can interpret to the nursery school teachers the complex behavior symptoms observed in the playroom. The parents are not left out of the treatment. Parent discussion groups are held regularly with a social worker as the leader. Some parents require individual casework with a social worker or psychiatric treatment with a psychiatrist. Weekly conferences are held with all members of the team contributing their findings to the discussion. Over a period of two or three years of intensive focusing on the family situation in this fashion the orientation of the members of the family group towards each other changes significantly.

Our Mental Assessment and Guidance clinic is another example of teamwork to help the family work out the problems that confront them in bringing up a mentally retarded child. As the name of the clinic suggests the primary purpose is to assess and guide. A child psychiatrist, who has at his disposal all the medical specialists of the hospital, heads up the team. Again the social worker and psychologist bring their professional talents to the working of the team. The knowledge that a complete and proper assessment has been carried out helps to make the guidance program which follows acceptable to the family. That it is done by a team of professional workers who have the interest of each individual in the family at heart, makes possible some of the very difficult decisions that often have to be faced.

Community Teamwork

Our psychiatric, social service and psychology staff members serve in the community agencies. In many situations their role is that of a consultant to help child care workers deal with the deviant behavior problems that arise in their young clients. Family welfare agencies, training schools, child guidance clinics and public schools are some of the children's organizations that use our professional help. The greatest problem to the professional worker in this field is the lack of proper community resources where children who require special understanding can either live or go to school.

Teamwork with associations interested in specific problems of children, such as the Cerebral Palsy Association, the Association for the Help of Retarded Children and the newly formed Society for Emotionally Disturbed Children has been a characteristic of the professional staff of this hospital. Many medical and other workers from other professions serve on the Advisory Boards of these associations and there is a free interchange of ideas with the lay members of these groups who are dedicated to establishing resources and improving the quality of education and medical service.

Some of the areas of teamwork have been briefly outlined to indicate to you how psychiatric services work with individuals, the family in the hospital and in the community. As you can gather our work is complex and requires time. There are few wonder drugs which can change the outlook in a short period of time. Because of the many hours and years of work and the number of resource people required to guide the individuals and families to a healthier mode of adjustment, child psychiatric care is expensive. Like other illnesses, prevention and early treatment will save misery and expense in the lifetime of an individual.

Justice is truth in action — BENJAMIN DISRAELI

Multiple Myeloma

ANNIE KUCZMAK

Etiology

MULTIPLE MYELOMA, or Kahler's disease, is a progressive, uniformly fatal disease. The name is derived from *myelos,* meaning marrow, and *-oma,* meaning tumor. There is rapid increase of myeloma cells which infiltrate the bone. The condition is probably due to neoplasm and spreads through the blood and lymphatics to the ribs, sternum, skull and vertebrae, causing pain, bone destruction, and pathological fractures. It is either the pain, or the pathological fractures that force the patient to consult a doctor. Myeloma cells also invade the soft tissues of the liver, spleen, uterus, kidneys, nerve roots, and spinal cord. In some patients a peculiar protein called Bence-Jones may be present in the urine, but this is not typical of all cases.

Myeloma cell itself was first differentiated from the Marschulko cell in 1900. In 1929, Arinkin began to study the cells by the aspiration of bone marrow from the sternum, iliac crest, ribs, and spine. These samples showed a variation of 2-90 per cent of the myeloma cells. The cell varies from a small, immature, dark blue, almost characteristic plasma cell to an immature anaplastic cell of 20-40 microns in diameter, in which the chromatin tends to clump.

The cause of this fatal disease is unknown. It appears to be more common in men than in women, by a ratio of three to one. Usually the onset of the disease is in the late fifties, and it rarely occurs under the age of 35 years. Any race or class of people is susceptible. From the onset of the initial symptom, which is usually pain, the average life expectancy is two and one half to three years.

The Patient

Mrs. Thomas, aged 61 years, entered the hospital undiagnosed and totally unaware that her clinical manifestations would point to multiple myeloma. By nature she was a happy, pleasant woman, full of ideas and with a zest for living.

Prior to admission, she had worked as a cook in a hospital in a small town. She had two children but they did not live in the province and were unable to come and visit her, so that she seemed very much alone. Mrs. Thomas had worked hard most of her life. She was a widow, and was definitely not secure financially. During her hospitalization she remained bright and cheerful, and worked continually on fancy work for the women's organization of her church.

Subjective Signs and Symptoms

Mrs. Thomas first remembered having numbness of her right foot three years previously which gradually disappeared. The left foot also became numb but with the help of medication (of which she did not know the name) and a blood transfusion she obtained relief. A year later numbness developed across the lumbar region of her back. She was placed on bed rest for three weeks. Five weeks prior to hospitalization Mrs. Thomas developed a cough, and a pain between her right shoulder blade and mid-back. A week of bed rest had given her only slight relief. Two weeks following this she developed a constant ache in her spine, which was near the level of the twelfth dorsal vertebra.

As a result of this final symptom she was unable to work and she consulted her local doctor. He referred her to an orthopedic specialist.

The original numbness of her feet was probably due to myeloma cells invading the spinal cord, or nerve roots, thus causing neurological symptoms. No doubt the spinal pain was due to a pathological fracture of the vertebrae. X-rays usually reveal a very moth-eaten appearance of involved bones due to destruction by the myeloma cells.

Miss Kuczmak, a student of the school of nursing, University of Alberta hospital, received honorable mention for this study in the Macmillan Award competition.

One of the most common early symptoms of multiple myeloma is pain, occurring in approximately 92 per cent of cases. It may have an insidious onset and be migratory, or it may be sudden following pathological fractures. In the latter instance pain may be either general or local, and usually is made worse by any movement or, in some cases, deep breathing. Pathological fractures occur in about 10-18 per cent of cases, and 59-97 per cent occur in only one bone, most commonly the spine or thorax. With the collapse of a vertebral body comes postural errors in the form of kyphosis and scoliosis. If symptoms of the fracture are severe the patient may be confined to bed. Neurological symptoms — sciatica, root pain, or indirect peripheral neuritis — may develop. With peripheral neuritis, weakness of the shoulder girdle and arm also may occur. Pathological fractures may occur in the femur, ilium, humerus, clavicle and pubis.

Another subjective sign of multiple myeloma, which was not evident in this instance, is the presence of palpable tumors on flat bones, particularly the thorax and skull, but also on the femur, lumbodorsal spine and humerus. These are due to diffuse hyperplasia of bone marrow, and range from the size of a pea, to the size of a grapefruit.

Objective Signs and Symptoms

On admission Mrs. Thomas appeared pale and thin but not emaciated. Her weight was 121 pounds. She had lost four pounds in the preceding six weeks. Her temperature was 98° F., pulse rate, 74, and respirations 22, all of which were within normal limits. In some cases of myeloma there is an elevated temperature, but Mrs. Thomas' temperature remained normal, with the exception of a few days when it went to 99° F. when she developed a head cold. Blood pressure was 136/66. X-rays of the spine revealed a wedging of D 12, complete collapse of D 9, and heavy calcification of the abdominal aorta. X-rays of the chest showed an enlarged heart, pleural thickening and atelectasis.

Abnormalities of the extremities — clubbed fingers and toes and irregularities of the nail beds — have been noticed in some cases of myeloma, but were not present in this case. Epistaxis, bleeding gums, hemoptysis, blood in stools, retinal hemorrhage, petechiae, and purpura of the skin occur in some cases, but again were not in evidence.

In advanced cases of myeloma the medullary cavity in certain bones is completely replaced by round or oval, gray, gelatinous tumors which can be scooped out and are hemorrhagic. In some cases the patient may develop rheumatoid or osteo-arthritis due to the deposit of amyloid about the synovial membrane.

Laboratory Results

In the diagnosis of multiple myeloma, laboratory investigation is very significant. The morphology report on the bone marrow taken from the sternum did not suggest myeloma cells, but indicated primary neoplastic disease of the reticulo-endothelial system. The proportion of red cells appeared reduced due to the increase in immature cells resulting from the destruction of the bone marrow in which the red cells are manufactured. The cells appeared to clump together, and suggested tumor cells.

Mrs. Thomas' hemoglobin was 83 per cent, or 12.0 grams and her hematocrit reading, 29 per cent, both of which were within normal limits. With destruction of the bone marrow, it can be easily understood why these patients eventually develop anemia, and require blood transfusions, which Mrs. Thomas had received some time before her admission. Her platelet count was 51,000 which was abnormal, the normal range being 140,000-340,000 per cu. mm. In most cases of myeloma the sedimentation rate is elevated. In this instance it was 14 mm./hour which is normal for a woman. The white blood cell count was elevated above the normal of 5,000-10,000 cu. mm. to 16,300/cu. mm. Blood urea nitrogen was 11 mg. which is within the normal range. The routine Kahn test for syphilis was negative. In 95 per cent of cases of myeloma, the serum protein will be elevated due to the products of bone marrow destruction. A routine urinalysis showed normal results with the exception of a trace of protein.

In a suspected case of myeloma, a single urine specimen, followed by a 24-hour collection specimen will be sent for examination in an attempt to locate Bence-Jones protein. If present, it points

definitely to the diagnosis of multiple myeloma. If not found, this does not eliminate the possibility of the disease existing since Bence-Jones proteins may be excreted only at intervals, and in some cases only late in the course of the disease. To locate Bence-Jones proteins, the urine is tested with sulphosalicylic acid. If this test is negative, the protein is not present.

In autopsies done on patients who had suffered from multiple myeloma 86 per cent showed nephritis, and 61 per cent revealed the presence of Bence-Jones proteins. The latter may be found in the kidney in three forms:

1. As large hyaline drops in the lumen of the tubules, and tubular epithelium.
2. As crystalline material in the tubular lumen and tubular cells.
3. As amorphous precipitate in the form of casts, and located as high as the proximal convoluted tubule. The entire nephron unit can be filled with the protein resulting in extreme distention, deformity and atrophy of the renal system. Renal damage may be caused from nephrocalcinosis, or by obstruction and atrophy of tubules caused by protein casts.

Treatment and Nursing Care

Mrs. Thomas was admitted with a tentative diagnosis of multiple myeloma. With this in mind the nurses planned her nursing care along prophylactic and supportive lines as there is as yet no cure for myeloma.

Prophylactic treatment consisted mainly of good basic nursing care. It was kept in mind that Mrs. Thomas had lost weight before admission and special care must be given to bony prominences.

Each day particular attention was given to the coccygeal area, both hips and legs as it caused her considerable back pain if she attempted to bathe these areas herself. She particularly enjoyed her alcohol back rubs, and would say to the nurses, "That back rub makes me feel so good. I think it helps relieve the ache behind my shoulder."

Cleanliness of the mouth was important and good dental hygiene was encouraged. Mrs. Thomas was most concerned about her general appearance, and was neat and well-groomed at all times. In this respect there was little indication for health teaching.

In treating the constipation caused, no doubt, by confinement to bed, Magnolax one ounce was ordered several evenings with good results.

Supportive measures included bed rest to relieve pain, and assistance in splinting the fractured vertebrae by lying on a firm mattress over a wooden fracture board. Body alignment was checked each time back care was given. Postural deformities develop readily in multiple myeloma, and although they cannot always be prevented, they must be reported. Although her hemoglobin was not low, the doctor felt that it was a sound idea to order 1000 cc. of blood for Mrs. Thomas. It was given without any untoward effects developing.

It was felt that a high caloric, high vitamin diet would help build up the patient's general condition. Patients with myeloma are frequently placed on a low protein diet, due to the increased serum protein. This rule was observed in treating Mrs. Thomas. She tolerated food well, although she frequently mentioned that she was not really hungry.

To confirm her diagnosis, the doctor ordered numerous tests. Many of these required special preparation and a delayed breakfast, and all required a thorough explanation. Mrs. Thomas was most cooperative. The one test she was somewhat dubious about was the "bone aspiration," as she called it. During this operation, a nurse from her own ward remained with her, and she tolerated the procedure very well.

Accurate charting was maintained on Mrs. Thomas throughout her hospitalization. The doctor was particularly interested in the amount of pain she had each day, and its exact location. Although few drugs were ordered for this patient, there are several used in the supportive treatment of multiple myeloma.

Stilbamidine, is given intravenously in doses of 50-150 mg. daily or on alternate days until a total dose of 4-5 grams has been given. The drug is given in conjunction with a protein diet. Stilbamidine must be given slowly, for if administered rapidly, flushing, dizziness, headache, nausea, vomiting, salivation, lethargy, rapid pulse, lowered blood pressure and muscle twitching may occur. There is also a danger of injury to the trigeminal nerve and resulting paralysis of the face with the use of this drug. It does, however, give marked although

temporary relief from pain, and allows the patient to resume normal activities for a period. It does not decrease the production of Bence-Jones proteins.

A derivative of Stilbamidine, hydroxystilbamidine isethionate, has the advantage of being less inclined to cause kidney complications or trigeminal paralysis and may be used in preference.

Urethane is a drug which may be administered orally for multiple myeloma. It has several advantages. It has a temporary effect upon pain. It inhibits the development of leukemia and the growth of certain tumors. It decreases the protein in the urine and brings the serum globulin back to normal. The bone density and hemoglobin tend to increase while hyperglobulinemia and hypoalbuminemia disappear. The dose of urethane is 2-4 grams per day until a total dose of 240-300 grams is reached. Urethane is very hard for many patients to tolerate. It frequently causes such severe nausea and vomiting that it must be discontinued. Toxic effects may result in leukopenia, liver damage, and thrombopenia.

Cortisone has been used in multiple myeloma, but should be administered only if there is a lack in the amount produced by the adrenal glands, and when excessive edema is present. The dose is generally 20 mg. q.6 h. for 20 days. Cortisone helps to decrease the serum globulin, the quantity of myeloma cells in the marrow, and the serum calcium. Toxic symptoms are generally manifested in loss of appetite.

Neo-stilbosan, is another drug that will help control hemorrhage, shrink the tumor masses, and improve the plasma proteins. Use of this drug is limited due to the high incidence of renal complications.

The use of x-ray therapy is not always very satisfactory in the treatment of multiple myeloma, but when used successfully it reduces the pain to a degree, and slows down the growth of the malignant cells. It may increase the patient's life-span by several months.

If pain becomes unbearable, even with the use of strong analgesics, a cordotomy may be done in patients where the spine and nerve roots are involved. This on the whole is not very satisfactory. Nitrogen mustard has also been tested, but its effectiveness has not been established as yet.

In spite of certain negative laboratory results, the doctor confirmed the diagnosis of multiple myeloma. It was his desire that she should not be told either her diagnosis, or prognosis and it was hard for members of the nursing staff to answer the questions she asked about the results of the tests. Realizing the hopelessness of the situation, and considering the stable type of personality that Mrs. Thomas appeared to have, many of the nursing staff felt that if she thoroughly understood her diagnosis, she could get the most out of life in the short time she had left. The doctor felt Mrs. Thomas had a few more months which would be relatively comfortable, and he did not wish to cloud them with such a sentence.

Conclusion

As there is no cure for multiple myeloma, the prognosis for Mrs. Thomas was very poor, in fact, hopeless. Much research has been done already for a method of controlling the course of this disease, and ultimately curing it.

Mrs. Thomas has an approximate life-span of one to three and one-half years. Before that time is spent, further complications of multiple myeloma will have developed. Pain, which unfortunately is one of the earliest symptoms, will become progressively worse requiring strong analgesics and eventually potent narcotics to control it. Anemia will increase in spite of blood transfusions. The patient tends to become more and more emaciated. With bone destruction and absorption, postural deformities will develop. Splints or braces may be required to give reasonable support. For a period she will be able to visit the orthopedic clinic within the hospital and will receive any necessary treatment and medications.

Before her discharge, Mrs. Thomas was made aware of the importance of avoiding damp or icy weather. It was explained to her that her bones were somewhat fragile and could not take the strain they could withstand normally. The types of food, low in protein and high in vitamins which she was advised to eat, were reviewed with her by the dietary staff.

The doctor mentioned to the nursing staff that he had contacted Mrs.

Thomas' son and had explained the prognosis. The son was most concerned about his mother as he had been completely unaware of his mother's illness. Being a thoughtful woman, Mrs. Thomas had not wished to worry her family with her troubles. The son planned to convince his mother to sell her small home, and live with him and his wife. Mrs. Thomas was discharged unaware of her diagnosis, or of her son's intentions but considerably more pain-free than on admission and thankful to be getting home.

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Pemphigus Vulgaris

GLORIA SOBIE

Definition

Pemphigus vulgaris is a rare, grave, chronic skin disease characterized by the eruption of bullae (large blisters filled with fluid) on apparently normal skin and mucous membrane. It usually occurs in the 40 to 60 year group. The cause is unknown and the course is often very long. The bullae may appear on any area of the skin. The neck, axillae, and inguinal areas are most commonly affected by the bullae which are usually resistant to treatment. The mucous membrane of the eyes and mouth are involved early or late in the course of the disease. These bullae do not rupture spontaneously, but become flaccid and their contents turbid. When they rupture, raw areas remain which do not become epithelialized. The outer layer of normal skin easily separates upon slight friction, *Nikolski's sign*, which is significant. When the lesions heal over, a brown pigmentation remains. Death often results from pulmonary infection such as pneumonia.

Miss Sobie, a senior student at the School of Nursing, University of Alberta Hospital, received Honorable Mention for this study in the Macmillan Award Competition.

Patient's History

Mrs. Rishikoff, a 50-year-old Polish woman, was admitted with ulcerations on her gums, tongue, and the mucous membrane of her cheeks. These had appeared three months previously. Ulcerations in the mouth are a positive sign of pemphigus, and often if they are severe, the patient has difficulty eating, swallowing, and sometimes breathing. Mrs. Rishikoff was having some difficulty eating, and swallowing, and was troubled with excessive salivation due to large denuded areas in the mucous membrane of her mouth. There was no history of other members of the family having had this condition. The patient's general condition at this time was good.

On her second admission to hospital a few weeks later, the bullae had spread to her neck, axillae, breasts, and back. Her face was swollen, which may have

been due to a low plasma protein level and large doses of cortisone.

The first test performed was the *Tzanck's test* in which the scrapings from the floor of the lesion showed a large number of epithelial cells and eosinophils. The results were inconclusive but aided in diagnosis. Mrs. Rishikoff's temperature on admission was 98.8, pulse 80, respirations 20, blood pressure 124/80 — all normal. Her weight was 190 pounds and indicated a gain due to the tissue edema. Laboratory studies both for hematology and biochemistry proved to be normal. Often a patient with this diagnosis has a slight increase in the eosinophil level and a decrease in plasma proteins, due to the loss of exudate from the bullae.

The bullae were about the size of a five-cent piece. They were filled with cloudy grey fluid. Many of the bullae had ruptured leaving raw surfaces on the skin, while some areas were crusted. Upon slight friction or pinching, the skin layers separated easily. She complained of a burning sensation, but no actual pain.

Mrs. Rishikoff's skin was deeply pigmented. Her face was swollen and she had a large mass of fat at the back of her neck which was similar to the *Cushing syndrome,* indicating a disturbance in the adrenal cortex. She looked much older than her stated age. She walked slowly, and appeared to be very weak and tired. Although many people who have pemphigus lose weight because of difficulty in eating due to the lesions in the mouth, this patient gained weight. She also appeared depressed and anxious.

Medical Treatment

1. Wet dressings to the lesions on the neck and other parts of the body every half hour during the day until all the blisters were broken and all the crusts removed.
2. Daily soap and water baths after which talcum was applied to the dry lesions and vaseline gauze with Neocortef ointment to the denuded areas.
3. Hydrogen peroxide and normal saline mouth washes alternated every hour.
4. Slow intravenous drips of 5 per cent glucose in water with 20 units of Duracton every two days.
5. Salt free diet.

Medications

Seconal gr. 1½ at bedtime every night to induce sleep because Mrs. Rishikoff was extremely anxious and had difficulty sleeping.

Potassium chloride gr. 15 t.i.d. to replace the loss of potassium caused by the cortisone products.

Neurotrasentin tablet 1 t.i.d. to act as an antispasmodic on smooth muscle and for sedative effect.

Phenobarbital gr. ½ t.i.d. to act as a sedative and help the patient to relax since she was very nervous.

Diuril ½ gram b.i.d. for three days to remove some of the extra fluid from the tissues.

Equanil 400 mgm. t.i.d. administered from two weeks after admission until her discharge to help her relax and to improve her morale.

Gelusil liquid 2 teaspoons t.i.d. before meals and at bedtime to lower the acidity of the gastric contents and overcome the gastric distress often caused by the use of cortisone for long periods.

Hydrocortone 20 mgm. and Meticorten 10 mgm. for two days to suppress the reactivity of the connective tissue against the unknown irritant causing pemphigus and thus control the disease.

Kenecort 12 mgm. q.i.d. started one month after admission and continued to discharge. It acts as an anti-inflammatory agent and produces hormonal and metabolic effects. It is very similar to cortisone.

Duracton 20 units in intravenous drips to suppress the reactivity of the tissue against the unknown irritant and to make the remissions of the disease longer and the complications fewer.

Nursing Care

When Mrs. Rishikoff was admitted, her nurse explained the hospital and ward routines, including in her explanation the fact that the patient would be given certain tests the following morning, which would necessitate taking samples of blood and delaying her breakfast until the tests were completed. A urine specimen was collected for routine checking.

The first treatment of the lesions was the application of "Domeboro wets" every half hour during the day. Domeboro contains aluminum sulfate and calcium acetate and when dissolved in water gives the therapeutic effect of

Burow's solution 1:20. To prepare "wets" large pieces of gauze were cut to cover specific areas. The gauze was 8-10 layers in thickness to prevent the dressings from drying too quickly. These pieces of gauze were soaked in a solution that was prepared by dissolving one package of Domeboro powder in one pint of water at room temperature. The wet dressings were changed frequently so that they would remain cool and moist. No plastic coverings were put over them as this would have defeated the purpose, which is accomplished by the evaporation of the solution. This treatment was used to lessen the irritation of the skin by reduction of the heat and inflammation, prevention of crusting, and keeping the skin clean so that the base of the lesions could be treated. Mrs. Rishikoff was given extra blankets to prevent chilling. Because she was in bed all day, she was given back care with alcohol and powder every four hours to prevent pressure areas forming on her coccyx and to promote comfort.

Vaseline gauze with Neo-cortef ointment was applied at night to promote healing and to help prevent new lesions from forming. These dressings also afforded a means of protection to the lesions. The Neo-cortef ointment was one way of supplying cortisone to the skin lesions. Each day it was noted carefully whether any new bullae had formed. If present, they were ruptured with a sterile needle, the serum pressed out with sterile gauze, and the dead skin trimmed away with sterile scissors.

When all the lesions had ruptured and all the crusts had been removed, Mrs. Rishikoff began taking daily soap and water baths. The temperature of the bath was carefully checked so that she would not burn herself or irritate already tender skin. Care was taken that she would not become chilled during or after the baths. Talc was applied to the dry lesions and vaseline gauze with Neo-cortef ointment to the denuded areas. Hydrogen peroxide in a weak solution and normal saline mouth washes, alternated every hour during the day, were given to heal the lesions in the mouth. Mrs. Rishikoff never had to be reminded to use her mouth washes, once she understood what she was to do. She firmly believed that the treatment would cure her instead of just controlling the disease.

The intravenous drip of 5 per cent glucose in water with 20 units of ACTH was given over an eight-hour period. The ACTH acted as a buffer against the irritant to which the skin was reacting. It seems to be effective in collagen tissue diseases and stimulates the adrenal cortex. While the solution was running close watch was kept for signs of an untoward reaction. Mrs. Rishikoff was told that the intravenous drip was a very important part of her treatment. It was explained that it would probably help in controlling the disease, but she must not expect it to cure the disease.

The patient was put on a salt free diet because ACTH and oral cortisone cause sodium retention with edema. The dietary restrictions were explained to her. Her weight was checked daily and recorded. Mrs. Rishikoff was most helpful since she was conscientious about checking her weight. Her appetite was fairly good, but she often mentioned that she missed the salt in her diet. However she stayed on her diet carefully because she felt that it was part of her treatment and very important.

The patient was apprehensive and worried about her condition. The doctor had explained the seriousness of her disease to her and continued to encourage her during the long term of treatment. Mrs. Rishikoff questioned the nurses and doctors repeatedly about any signs of improvement in her lesions and, at first, kept the curtains drawn around her bed since she was afraid that the other patients would dislike her appearance. She did not socialize well with other patients generally. The nurses tried to entice her to take part in ward activities, but she soon became bored and retired to her bed. She was encouraged to have visitors, but her husband and son were the only ones.

Although she was urged to rest for short periods during the day because of her nervousness and anxiety, she was also encouraged to go for walks in the hall. Some Sundays she was allowed to go home on pass. When she was up, she was told to keep out of drafts and to dress warmly so that she would not get chilled. When the

lesions began to dry and very few new ones were appearing, Mrs. Rishikoff became more relaxed and began socializing with the other patients.

After approximately four months of treatment in hospital she was discharged. The lesions on her skin and in her mouth had healed. She was to take cortisone drugs at home, and report for periodic check-ups to her doctor. She was more relaxed and had accepted her condition well, even though she knew it would mean repeated periods of hospitalization in the future.

Possible Complications

1. The lesions may become secondarily infected if they are not kept clean.
2. Pressure areas may develop from being in bed too long, and from not moving about, especially with an intravenous running for a long period.
3. Severe involvement of the mucous membrane of the mouth and throat may cause difficulty in swallowing. Keeping the patient hydrated and well-nourished may be a serious problem.
4. Pulmonary infection is often the cause of death in pemphigus, especially in bedridden patients.
5. Toxemia is quite often the cause of death.

Emotional and Social Problems

Mrs. Rishikoff had a difficult time adjusting to her ilness. She continually asked for reassurance that she would be cured. She was so worried and upset that she had trouble sleeping. She appeared to be much older than her 50 years. At first she did not care to socialize with the other patients since she was so conscious of her condition and appearance. It was difficult to assess the family's reaction to the patient's appearance and to the length of her illness. The patient would require constant encouragement and understanding from her husband.

Mrs. Rishikoff had Blue Cross insurance which helped pay for her hospitalization. However, she was worried about the cost of the cortisone and ACTH, especially since it was necessary that she continue taking them at home.

Health Teaching

Mrs. Rishikoff was told to continue with her daily rest periods after discharge. She was told to keep the areas of skin that had been affected as clean as possible, so that they would not become reinfected. She was to continue using the talc and taking daily baths. She was *not* to use any remedies of her own on the lesions and she was warned to be conscientious about taking her cortisone drugs. The dietitians instructed her concerning the salt free diet that she would have to follow.

Because pneumonia is a frequent and serious complication of pemphigus, she must be particularly careful to avoid upper respiratory tract infections. If any new lesions occur she must report them to her doctor as soon as possible. She was instructed to take up her usual life at home, doing as much housework as she could manage, and to participate in community activities.

Prognosis

The prognosis of the disease is very poor, but it may take months or years to reach termination. With the use of cortisone, remissions may be prolonged keeping the patient more comfortable and allowing her longer periods at home. She will be able to do her own housework temporarily, because the disease has not affected the skin on her hands, and pemphigus is not considered to be contagious.

To assist the individual nurse or the governmental or other health agency in planning for postgraduate study in nursing, the Florence Nightingale International Foundation has made available two lists of the advanced educational programs in all countries where such facilities are available. Published by the International Council of Nurses, 19, Queen's Gate, London, S.W.7, England, the publications are: *An International List of Advanced Programmes in Nursing Education* (1951-1952), $3.00 and *Supplement to an International List of Advanced Programs in Nursing Education*, 75 cents.

* * *

The man who does not read good books has no advantage over the man who *can't* read them.

— MARK TWAIN

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Financial Assistance for Nursing Education

ALICE GIRARD, our President; HELEN MUSSALLEM, Director of the Pilot Project for the Evaluation of Schools of Nursing in Canada and PEARL STIVER, General Secretary met with the Dominion Council of Health at their April meeting to discuss a brief on financial assistance for nursing education.

This brief was prepared following a visit of our president and the general secretary to the Hon. J. WALDO MONTEITH, Minister of National Health and Welfare. It presented the need for financial assistance to existing schools of nursing:

for the establishment of new and experimental educational programs,

to individual students to enable them to complete the basic educational requirements to enter nursing,

to graduate nurses to enable them to take advanced study which will qualify them for senior nursing positions in administration, consultation, education, supervision and research.

The brief was received by the Dominion Council of Health with keen interest. In spite of a lengthy agenda, one full morning was given over to this particular item.

As a result of the meeting, the CNA delegation has been invited to meet with the Technical Conference on Hospital Insurance when it meets in Ottawa this autumn.

CHA 15th Biennial Meeting

The Canadian Nurses' Association was pleased and honored to participate in the program of the Canadian Hospital Association held in Montreal in May.

Representatives of the CNA took part in a panel discussion entitled "Toward Better Nursing." Areas of nursing service and nursing education were dealt with as outlined in the CNA Policies Regarding Nursing Service and Nursing Education, also known as Toward Better Nursing.

Discussion centred around nursing service, particularly in the hospital; nursing education programs offered in Canada today; and the Pilot Project for the Evaluation of Schools of Nursing in Canada.

Participants in the program were:

Chairman — Miss Alice Girard, President, Canadian Nurses' Association

Representing Nursing Service — Sister Mary Felicitas, Chairman, CNA Committee on Nursing Service
Miss Ella Howard, Chairman, RNAO Committee on Nursing Service.

Representing Nursing Education —
Miss Hazel Keeler — Chairman, CNA Committee on Nursing Education
Miss Helen Mussallem, Director Pilot Project for the Evaluation of Schools of Nursing in Canada.

The CNA extends thanks to the CHA for the opportunity to participate.

National Committee Meetings

NURSING SERVICE

A meeting of the Sub-Committee on Nursing Service was held in May. Discussion centred around:

the study of the social needs of the nurse in both the rural and urban settings,

causes of turnover of nursing staff,

the report of the ILO Ad Hoc Committee on "Conditions of Work and Employment of Nurses,"

a review of the present CNA Statement of "Recommendations on Personnel Practices,"

the implications for nursing in hospital insurance and diagnostic services.

NURSING EDUCATION

A meeting of the Sub-Committee of the Committee on Nursing Education was held in April followed by a second meeting in May. Helen Mussallem, Director of the Pilot Project, was asked to attend the May meeting and assist in planning the procedure for further study of Canadian Criteria for the Evaluation of Schools of Nursing.

Last February the Executive Committee of the Canadian Nurses' Association approved the recommendation of the Committee on Nursing Education to undertake a study of personnel providing instruction in schools of nursing. A questionnaire has been formulated and will be forwarded to the provincial associations. September, 1959, has been selected as the month in which the survey should be undertaken. This project is an implementation of Policy 4 of the CNA Policies Regarding Nursing Service and Nursing Education.

The Planning Committee for the Curriculum Workshops met in May. This workshop will be held in conjunction with the annual fall meeting of the National Committee on Nursing Education. Members of the committee will be involved at this time with the preparation of the CNA Proposed Guide for Curriculum Construction.

Pilot Project for the Evaluation of Schools of Nursing

Since the launching of the Pilot Project for the Evaluation of Schools of Nursing in Canada, considerable interest has been expressed by individual nurses, nurses' associations (local and provincial) and affiliate professional organizations. These individuals and groups have felt the desire and need for further interpretation of the program and have requested the assistance of Helen Mussallem, director of the Project, to fulfill these needs.

Institutes and workshops on accreditation have been planned in some provinces. Hospital associations have included accreditation of schools of nursing on their annual meeting programs and have requested that the director participate in these programs. Local chapters have also asked for interpretation of the project.

The Canadian Nurses' Association is gratified with the interest and enthusiasm that the membership has shown throughout the past year and wishes to remind all concerned that resource persons are available to assist with the planning of workshops, institutes, meetings, etc., and to participate in such programs.

If you are planning a program on accreditation do not fail to write to:

National Office,
Canadian Nurses' Association,
270 Laurier Avenue West
Ottawa, Canada

Let us know your plans.
We will be pleased to assist you.

The Exchange of Privileges Program

During the first six months of 1959, Canada has received 28 nurses from England, Scotland, Australia, Denmark, Holland and India on study scholarships, some of whom remained for a limited period of time in positions.

Each of these international visitors has come on Exchange of Privileges with the recommendation of their national associations. The requests of the many national associations for assistance in planning and implementing programs for these scholarship nurses have been most satisfactorily fulfilled.

The Canadian Nurses' Association seeks this opportunity to pass on the gratitude and feeling of satisfaction of the individual nurses and the appreciation of their national associations to the provincial associations who have planned such an interesting variety of programs. Their appreciation goes also to those hospital and nursing agency personnel who have given so much of themselves and have provided observational opportunities and unlimited resource materials for international visitors.

The Exchange of Privileges Program places on Canadian nursing, a tremendous responsibility, but in so doing, provides Canadian nursing with the privilege of exerting a far-reaching influence in all areas of nursing.

A great number of Canadian nurses are also travelling on the Exchange of Privileges Program to various countries for added experience in nursing and for specific postgraduate study.

Our appreciation on behalf of these nurses is extended to the national associations of France, England and Scotland, Denmark, Sweden, Holland, United States and Australia.

Mental Health Week

Canada's Mental Health Week in April had particular significance for the Ottawa Study Group on the Psychological Problems in General Hospitals when Miss ELIZABETH BARNES, international study coordinator for the World Federation of Mental Health, London, England, was entertained by the group and spoke on the development of this program in the 13 countries undertaking the study.

Reports on projects conducted in each of the hospitals and agencies represented, were presented and discussed and will form the basis for future discussion and study on communication between:—

Nurse
Doctor
Senior staff
District social worker
District nurse
} Patient

and the inter-staff communication for improved patient care.

Saskatoon and Kingston, both in university settings, are in the process of forming similar groups. We trust there will be many others. There is real opportunity, challenge and purpose.

Under False Colors

IF YOU ARE A DIRECTOR of nursing or concerned in any way with employment of nurses, how carefully do you check credentials? Generally speaking, application by a nurse for a position entails a definite routine — an interview with the director of nursing, submission of registration and school of nursing credentials, letters of reference, a specific history of past experience. There would appear to be variations in the degree of conscientiousness with which this pattern is observed since it seems to be relatively easy for an individual to misrepresent herself as a nurse and obtain employment on a professional basis.

There are a number of reasons for the frequency with which misrepresentation occurs. In some instances, the facts and the credentials presented may be so convincing that no cause for suspicion is given. But there are undoubtedly other occasions when the director of nursing, who is pressed for staff, examines credentials less critically and fails to follow through on the references given. She accepts the applicant on her face value, thankful that an extra pair of hands has appeared at the opportune moment.

If the employing agency is an industrial or business firm, the personnel officer may be unaware of and unfamiliar with the credentials of a registered nurse or may accept what the applicant has to say about her qualifications without asking for documentary proof.

The ruses of those who practice misrepresentation are varied as the following examples will show:

A graduate of an approved school of nursing in one province did not sit for her registration examinations. Later she applied for registration in another province submitting false information for the purpose. Her information was convincing and she was granted registration. She subsequently returned to her home province where she attempted to establish registration on the grounds that she had written her registration examinations and obtained professional standing in the second province.

A person was employed as a registered nurse by a large construction firm in a Western province. The company did not investigate her status at the time. Later investigation revealed that she had been a Red Cross worker in Germany.

A woman submitted a registration card which was found to belong to a nurse in another province. Investigation revealed that the real owner of the card

was a patient in a sanitarium where the would-be impersonator had recently been employed as a nurse aide. The holder of the card had claimed that the name on it was her maiden name.

A girl with 18 months' training as a nursing student in a mental hospital and five months' affiliation experience in a general hospital sought and obtained employment as a graduate nurse in a small hospital. No professional documents had been requested in connection with her application.

A woman claiming to be a graduate of an approved school of nursing applied for a number of positions within a province. She was found to have a record of involvement with narcotics on two different occasions.

The wife of a graduate, but non-registered, male nurse obtained employment in three or four small hospitals by misrepresentation.

A ward aide succeeded in securing a duplicate diploma and graduation pin of a registered nurse with whom she had worked.

Another individual attempted to secure duplicate professional documents of a registered nurse who had left a province. The request for the duplicate credentials was received at approximately the same time as the request for inactive membership by the registered nurse! An alert stenographer questioned the two requests made in the same name but originating from different provinces.

Many other instances of misrepresentation could be cited. Often the individual involved has had only a short course in nursing or has failed to complete the three-year general course.

What can be done about this problem? The responsibility must be shared by each one of us. Individually, we should be more aware of the potential for misuse of our credentials if they fall into the hands of unscrupulous persons. School pins and certificates, provincial registration or licensing cards should not be left carelessly exposed to possible theft. Nor should we discuss our individual professional status too freely in the hearing of casual acquaintances or strangers.

If and when a professional nurse suspects misrepresentation, she should feel under obligation to report the matter to proper authorities — the director of nurses or her provincial office, for example. There apparently is a need for more information by employers of nurses in industry regarding the credentials which a registered nurse should have and the importance of having her present them when applying for a position.

Many hospitals have instituted the practice of requiring the registered nurses on their staffs to submit proof of current registration once yearly. Such a procedure may help to eliminate the individual posing as a nurse and lacking credentials or possessing them illegally. It may also serve to bring to light irregularities in documents. For example, the married woman who claims that the name on her registration card is her maiden name should be asked to show a marriage certificate when she is not well-known to her director of nursing or employer.

Nurses requesting employment should submit, or be requested to submit, credentials before being engaged on a professional basis. There should be follow-up work done on the references given and critical inspection of the documents presented. Where any question arises concerning the individual's professional standing, she should either not be hired or else placed on a nursing aide basis until the matter is cleared. The various provincial registrars are obtaining more and more information concerning the standards of schools in various foreign countries. They can easily help the applicant who has a problem to determine her standing and the steps necessary to bring her to full professional status. They are also prepared to follow through with the investigation required to try to prove misrepresentation if such is suspected. J.E.M.

Independence? That's middle class blasphemy. We are all dependent on one another, every soul of us on earth.

— GEORGE BERNARD SHAW

The silliest woman can manage a clever man; but it needs a very clever woman to manage a fool!

— RUDYARD KIPLING

The Responsibilities of the Public Health Nurse

RITA DOYON

PUBLIC HEALTH NURSING, like other community services, has developed under the pressure of social, economic and technical needs. The giddy speed with which discoveries have been made in the scientific world, in production, transportation and communications has produced a corresponding growth in professional services. But in spite of the fact that we can now ponder about the possible uses of atomic energy, that we can travel faster than sound, that we have "miracle" drugs at our disposal, we have a long way to go before we achieve the cooperation and understanding necessary to preserve health. In a world where we should be able to live happily and securely, we find fear and tension on all sides and an overhanging threat of war.

Such an environment produces definite effects on the mental and physical health of the individual. As professional people we must cultivate greater understanding of ourselves and our fellowmen so that we may help them as well as ourselves. The health nurse (and this term includes any nurse engaged in public health work) in a modern unit has great responsibilities:

1. Responsibilities to the employing agency.
2. Responsibilities to the public.
3. Responsibilities to the profession.

Responsibilities to the Agency

She must be familiar with the philosophy, function and aims of the agency. She must know the problems to be faced and be resolved to allow for growth.

Personnel policies and procedure manuals must be accessible to each member of the health unit to ensure good relationships and a sense of security. The nurse who does not know what is expected of her, who is subjected to decisions and recommendations that vary from day to day or at the whim of the person in charge, will adjust poorly. She will be uncertain, will tend to form wrong impressions about the organization as a whole. While she herself may not suffer, the agency will. Conscientious and loyal by nature, the nurse could not remain for any length of time in such an atmosphere.

On the other hand when there is an atmosphere of fairness, congeniality, appreciation of individual worth, the nurse becomes and remains loyal and is proud to help in the growth and progress of the unit. She will realize that her role as a member of the team is an essential one. She will cooperate with the medical officer and all others with whom she comes in contact — parents, teachers, health inspectors, clergy — all those whose business it is to promote and protect health. She will not forget that her behavior, both in public and private life, will reflect on her agency and that a service subsidized by public funds is subject to criticism — often unjustified unfortunately. If she must wear a uniform, she should do so with dignity, conscious that she is in the public eye. She will refrain from gossiping to her superiors, her colleagues, and her friends.

Responsibilities to the Public

The nurse must understand and accept the fact that everyone has a right to her services without prejudice as to religion, race or language. Illness knows no boundaries or social barriers.

One of the nurse's first responsibilities is to find out about the people who make up the district or county assigned to her. It will be impossible for her to understand the people and adapt her teaching if she ignores the special customs of the locality. She must become familiar with the customs of the various technical groups. She must not expect that because she teaches or recommends certain measures, everyone will accept them immediately. It would be wonderful in public health work if we only had to speak once to see our ideas accepted!

Miss Doyon is a supervisor with the Department of Health, Montreal.

The nurse, as she watchfully tracks down the illnesses or nutritional deficiencies of the group with whom she works and the health hazards common to the area, will act as a sentinel, knowing where to refer problems which she cannot solve herself. As required, she must be able to teach patient care — it must be remembered that she is, first of all, an educator. To teach good living habits, to promote health and to prevent disease are the prime reasons for the existence of a public health service.

If she is truly interested in her work, the nurse will often ask herself the following:

1. Do I take the trouble to listen to what people tell me?
2. Do I really understand what people try to tell me?
3. Do I take the time to answer questions and are my answers at the level of my listener's understanding?

The health nurse then is an educator, an interpreter, a visitor, who stimulates, comforts, encourages and who is, above all, a friend.

She has a responsibility to keep up-to-date on new developments within the fields which affect her work. The physical health of the individual is the nurse's daily concern but she must be careful of her own mental and emotional health. She knows that an upset, nervous individual cannot remain in good health for long. Not only does she watch for symptoms of illness but she is equally observant of the indications of good mental and physical health. The devoted nurse, conscious of the role that she plays, becomes a respected figure in our communities. She realizes that an important part of her work is with the children who will be the citizens of tomorrow.

Responsibilities to the Profession

The nurse has a great responsibility towards her profession. She is a member of a professional group and, as such, she has certain duties to perform and a position to maintain. She should not practise unless she is registered or licensed as an active member of her provincial nurses' association. Subscribing to her professional journal is not enough. She should read it, understand it and contribute to it. Reading keeps her up-to-date with new methods and other information necessary in her work.

While professional subjects are very important, reading of a general nature should not be excluded since this provides the background necessary to understand people and their religious, racial and social differences. In regard to reading, the nurse should remember that the general public eagerly reads the articles on health and medicine that appear in the daily press or in magazines. She must be able to discuss the information so presented and give a fair estimation of the author and his ideas.

The public health nurse must be ready and willing to participate actively in meetings touching upon nursing functions, in studies within her own organization, in committee work. Such contacts contribute to the betterment of the services which she offers. New ideas are put at her disposal that tend to increase the interest and effectiveness of her work.

When she first considers doing public health work, the nurse should make up her mind, first of all, whether she feels competent for the job. If she has no particular desire or aptitude for this type of work, she will do both the agency and herself a good turn by looking for work elsewhere. Initiative, the ability to think, good judgment, patience and understanding are the factors that will decide whether her work is enriching or boring. She needs good mental and physical health. How can she teach good health habits unless she sets an example herself? Finally, her enthusiasm and zest will last as long as the nurse feels the desire to serve her fellows in this particular field.

Some people think that charity is giving to others the advice they cannot use themselves.

— *English Digest*

You'll find that the man at the top got there because he was at the bottom of a lot of worthwhile things.

— *Selected*

Nursing Profiles

Late last fall the *American Journal of Nursing* acquired a new editor, **Barbara G. Schutt.** A graduate of Jefferson Medical College Hospital School of Nursing, Philadelphia, Miss Schutt received a Bachelor of Arts degree in psychology from Bethany

BARBARA G. SCHUTT

College, West Virginia, and a master's degree in nursing education from University of Pennsylvania.

During World War II she served in Hawaii and Okinawa as a member of the Army Nurse Corps. Following discharge she became assistant executive secretary of Pennsylvania State Nurses' Association and in 1957, executive secretary. She resigned her post to take over her present duties.

Barbara Tate has been appointed part-time editor of *Nursing Research*, a publication of The American Journal of Nursing Company. Miss Tate has been working on her doctoral degree in education at Teachers College, Columbia University, where she is research associate and project director at the Institute of Research and Service in Nursing Education.

Manitoba nurses were delighted to learn that **Bente Hejlsted** had been appointed director of nursing services for the Sanatorium Board of Manitoba. Miss Hejlsted took over her new duties early this year.

A graduate of the Municipal Hospital, Copenhagen in 1951, she came to Canada in 1955 and was appointed a charge nurse at Manitoba Sanitarium, Ninette. Prior to this she had been nursing in England. In 1957 Miss Hejlsted became superintendent of nurses at Clearwater Lake Hospital, The Pas. During the few years that she has been resident here, she found time to study for and obtain her certificate in teaching and supervision from the University of Manitoba. Now her colleagues are looking forward to her very active participation in nursing education within the province.

Travel is one of her hobbies and this gives added scope to her interest in photography. For quieter moments Miss Hejlsted enjoys classical music and more study which undoubtedly takes in many other subjects than those related to her profession.

Early this year **Doris Harriet Smith** was appointed director of nursing, Belleville General Hospital. Born and educated in Belleville, Miss Smith graduated from her hometown hospital in 1946 and then com-

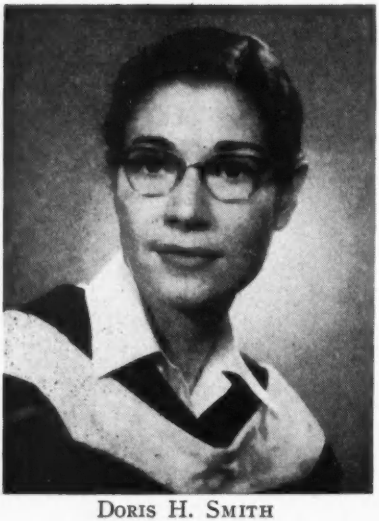
(Stone Studio)

BARBARA TATE

BENTE HEJLSTED

pleted requirements for senior matriculation before going on to university study. In 1955 she obtained her diploma in nursing education from the University of Western Ontario and in 1957 received her Bachelor of Science degree in nursing.

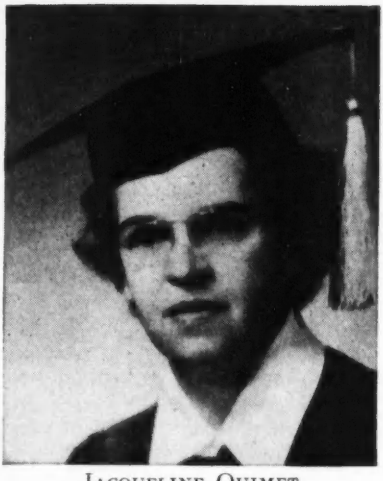
Miss Smith was the supervisor of student health and auxiliary personnel at B.G.H. for a time. Later she was responsible for the inservice educational program at the Hamilton General Hospital. She returned to B.G.H. to become medical-surgical supervisor and then pediatric clinical instructor. A member of the local branch of the University Women's Club, she is also on the board of the Belleville Children's Aid Society.



DORIS H. SMITH

Jacqueline Ouimet joined the staff of the Association of Nurses of the Province of Quebec recently as assistant visitor to schools of nursing. A native Montrealer of French-Irish descent, Miss Ouimet received her early education and business training at Académie St. Urbain and the mother house of the Congregation of Notre Dame.

Experience in the business world was followed by professional preparation at Notre Dame Hospital school of nursing, Montreal from which Miss Ouimet graduated in 1948. Postgraduate study at the New York Polyclinic prepared her for teaching and supervision in medicine and surgery and in 1950,



JACQUELINE OUIMET

further study at Institut Marguerite d'Youville brought a baccalaureate degree in nursing education. Miss Ouimet served as night supervisor and later as clinical instructor in medicine and in surgery at her home hospital before becoming assistant director of nursing in 1953. She resigned to take over her present duties.

She has taken a very active part in the affairs of her professional association as a member of various committees, as a vice president of District XI French chapter, as a member of the Committee of Management, A.N.P.Q. Off-duty she is a photography enthusiast, likes to travel, and enjoys reading and study.

Sister Victoria Morton of the Religious Hospitallers of St. Joseph, Hotel Dieu Hospital, Kingston celebrated her diamond jubilee in professional and religious life in April of this year. She entered the community in 1897 and has been actively engaged in nursing within the hospital since 1899. She is presently the supervisor of a private pavilion in Hotel Dieu. Sister has been an active member of the R.N.A.O. since it was first formed in 1923. Hundreds of congratulatory letters have been received from those for whom she has helped to care or who have benefited in some way from her store of accumulated knowledge, her friendly interest in people, her example of dedicated service.

SISTER VICTORIA MORTON

Margaret L. Peart has resigned as director of nursing, Belleville General Hospital, a position she had held since 1952. A graduate of St. Joseph's Hospital, Hamilton, Miss Peart had been nursing arts instructor there immediately prior to her work at B.G.H. She is now administrative assistant (nursing) at Doctors Hospital, Toronto.

Annie (Merrylees) Boyer has retired from Guelph General Hospital as supervisor of the Central Supply Room. A graduate of Victoria Hospital, London in 1927, Mrs. Boyer engaged in private nursing in Stratford, Ont. for some time before joining the staff of the Municipal Hospital, Kerrobert, Sask. Later she returned to Ontario where she has given active service within the institution and in the provincial organization.

In Memoriam

Blanche (Crandall) Anderson, a graduate of Royal Victoria Hospital, Montreal in 1918, died on April 19, 1959.

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Ida Beatrice Brand who graduated from Hamilton General Hospital in 1926, died on May 3, 1959. After engaging in private nursing for a short time, she joined the outpost hospital department of the Red Cross Society. At the time of her death she was director of the Ontario Branch of outpost hospitals for the Canadian Red Cross Society and the president of the Soroptomist Club of Toronto. Always active in her professional organization, Miss Brand was a member of the Board of Directors, R.N.A.O. and chairman of the provincial committee on finance.

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Irene I. Clark, a graduate of Royal Victoria Hospital, Montreal in 1916 died on April 3, 1959.

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Dorothy Eileen (Buck) Croteau, a graduate of St. Paul's Hospital, Saskatoon in 1933, died on March 30, 1959. She had engaged in private nursing for a short time.

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Alice (Jewitt) Fox who graduated from Regina General Hospital in 1932 died on April 28, 1959.

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Ida May (Bishop) Jewsbury, a graduate of Misericordia Hospital, Winnipeg in 1932 died in Vancouver on April 23, 1959.

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Mrs. W. B. (Smith) Greenwood, a graduate of Deaconess Hospital, Boston, died on March 31, 1959 in Windsor, N.S. She was 82 years of age.

Viola Mackie who graduated from Toronto Western Hospital in 1932, died on March 25, 1959. She had engaged in private nursing until early this year.

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Alexis MacKinnon, a graduate of Charlesgate Hospital, Cambridge, Mass., died on December 4, 1958 from the effects of a fire which destroyed the home in which she was visiting. Her most recent appointment had been as matron of the Tuberculosis Unit, City Hospital, Sydney. She had filled this position until the unit closed.

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Margaret Montgomery who graduated from St. Luke's General Hospital, Ottawa in 1922 died on March 27, 1959. She had engaged in private nursing for some time.

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Edna A. (Smyth) Patrick who graduated from St. Elizabeth's Hospital, Humboldt, Sask. in 1936 died March 27, 1959 in Sherbrooke, P.Q. Mrs. Patrick had served overseas with the R.C.A.M.C. during World War II.

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Lillian E. Risebrough, a graduate of St. John's Hospital, Toronto in 1927, died on April 7, 1959. She had retired from active nursing in 1957.

Roseleen Doris (O'Brien) Sampson who graduated from Misericordia Hospital, Edmonton in 1940 died in April, 1959. During World War II she served with the R.C.A.M.C. in Canada, England and Europe.

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Lois Jane (Klockow) Schneider, a graduate of Regina General Hospital in 1932, died on April 19, 1959.

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Marguerite E. (Hopper) Shoemaker who graduated from Hamilton General Hospital in 1925, died at St. Catharines, Ont. on March 25, 1959.

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Pearl (Wallwin) Shuttleworth, a graduate of Brandon General Hospital in 1931, died on March 26, 1959. In accordance with her wishes her eyes were donated to the Eye Bank of the hospital — the first such bequest for this Bank.

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Isobel Smith, who graduated from Vancouver General Hospital in 1902, died recently. During most of her professional career Miss Smith engaged in public health nursing, first as a school nurse in Vancouver, later as a staff member of the Metropolitan Health Committee. She had retired a number of years ago.

In The Good Old Days

(*The Canadian Nurse* — JULY, 1919)

Endowment of Motherhood: The Family Endowment Committee in England proposes that the State provide a regular weekly income for families with children under fifteen years of age. This is meant to induce earlier marriages and remove the economic restriction on natality.

The claims of mothers seem at last to be coming to the front, and motherhood will soon be a popular profession. The French have founded a society in aid of nursing mothers.

* * *

Long Resection of Intestine: In the *Annals of Surgery* some remarkable operations are described. In a case of ileocecal tuberculosis, causing partial obstruction of the small bowel, ten feet were removed of the small intestine, also the cecum and eight inches of the ascending colon, which was united to the transverse colon. The *patient recovered.*

* * *

Malaria: The word malaria is compounded from two Italian words, *mal* and *aria,* meaning "bad air." The record of malaria reaches back to Hippocrates, who lived 400 years before Christ. Hippocrates divided the disease into the "every-day-chills" and the "every-other-day-chills."

* * *

Baby Welfare Exhibits which were started in Montreal, have been a powerful factor in awakening public interest in the welfare of the infant population in Canada, and have been responsible in a great measure for the progress accomplished in this direction during the last few months. It is confidently expected that a new impetus will be given to the work of baby welfare.

Familial Hemolytic Anemia

SISTER ELISABETH MARIE DE LA SAGESSE, F.D.L.S.

Introduction

THE STUDENT NURSE who looks up the chapter on the diseases of hematopoietic organs in her pathology textbook will find that hemolytic anemia is characterized by the dissolution of red blood cells. To her, this classic definition remains an abstract until the day when she starts giving nursing care to a patient with the disease.

This experience was mine. I began to understand hemolytic anemia when Therese came to the hospital as an emergency patient in the medical service.

The Disease and its Treatment

The child was seven years old. On admission she was very weak, almost unconscious. Her color was a straw yellow. A severe chill and an enlarged spleen gave the physicians an indication of the possible diagnosis. However, in order to confirm their impressions, they relied on the results of laboratory tests. Subsequently, these tests served to guide the treatment.

The hemoglobin content and blood count were indicative of serious anemia. The hematocrit reading was below normal. A marked increase in reticulocytes showed the effort of the body to compensate for destroyed elements. The presence of hemolyzed red cells was revealed by urinalysis.

During the first days of hospitalization, while Therese was unable to take food by mouth, intravenous solutions were administered. When an improvement in her condition became apparent, the prescribed treatment was rest, high protein diet, and blood transfusions.

Nevertheless, the hemolytic crisis which had necessitated hospitalization recurred many times. The child developed a more pronounced icteric color, and her curled up posture in bed indicated the intensity of abdominal pain. The spleen became palpable and the urine took on the characteristic color of this condition — orange, even bright red. Moreover, listlessness and lack of appetite were quite marked.

Complete rest was imperative during the acute stage of hemolysis. Fruit juices were included in the light diet prescribed in order to increase caloric intake. Intravenous solutions were given — 5% glucose and Ringer lactate — and aspirin, five grains q. 4 h. helped to stabilize body temperature, and relieve abdominal pain.

In spite of intensive medical treatment, surgical intervention became necessary. In hemolytic anemia splenectomy is often indicated. For some unknown reason, the spleen causes hemolysis. Its removal promotes restoration of the blood to normal.

The plan of this study does not permit the inclusion of all of the surgical aspects of the disease. However, preoperative nursing care should be noted. Psychological preparation, even of a seven-year-old child, is extremly important. Expressed in appropriate terms, an explanation of why an operation is necessary, and the advantages to be gained from it gives even such a small child an understanding of the situation. This attitude gives the young patient a feeling of security, which is much more desirable than an atmosphere of secrecy. In spite of natural apprehension, Therese was proud to be treated as a collaborator of the physician and nurse.

After the operation, the little girl cooperated readily in her postoperative care. She was interested in the healing of her incision; she understood the importance of eating properly and the necessity for becoming more active gradually. Control tests demonstrated the success of the operation. Therese left the hospital, able to look forward to a comparatively normal life.

Rehabilitation

It must be remembered that, from the physical point of view, a splenectomy deprives the body of an important source of red blood cells. This lack must be compensated for through-

Sr. Elisabeth Marie de la Sagesse is a graduate of Ste-Justine's Hospital, Montreal.

out life by a high protein diet rich in vitamins and mineral salts, especially iron. Anemia will thus be prevented and normal growth ensured. Moderate physical activity is essential. Before hospitalization, Therese was forced to follow very restricted activities because of poor health. A gradual return to the normal life of a little girl will avoid fatigue. The child's posture should be checked frequently. She had become stooped during her illness and postural defects readily occur at this age. Since the body's resistance is diminished, chilling should be avoided, and even mild infections must be promptly treated.

From the psychological point of view, it should also be remembered that the slow development of some diseases, sometimes causes particular complexes. The one to watch for most carefully is the adoption of the mentality of a sick person. This attitude is aggravated by a home environment that evidences either over-protection, or indifference. The child then uses the pretext of her illness to exploit the persons in her environment and prolong her incapacity.

Parents should be understanding and tactful, but also firm in order to help the child to become a normally adjusted person.

Experience acquired

The most fruitful experience was to convince me of the importance of giving intelligent nursing care. The three principles of the medical treatment of anemia are, as we know, rest, diet and blood transfusions.

With regard to the diet, numerous small details encourage eating properly: an attractive tray, a reasonable time in which to eat, the nurse's interest in the food presented, and her explanation of the reasons why certain types of food are included.

Rest is more than a prolonged stay in bed. If the bed is not comfortable or is not frequently tidied, if certain objects are not within the child's reach — a glass of water or fruit juice, a pet toy, etc. — the rest period soon becomes annoying, and therefore is not relaxation.

Transfusions require complete immobility of the patient. Discomfort can be reduced by frequent observation of the following points: Does the child need a drink? Is her position comfortable? Does she feel pain in her arm?

Conclusion

The nursing profession rarely requires spectacular action, but a nurse's days are woven with small details which constitute good basic nursing care. In a pediatric hospital, the daily contact of the nurse with childhood and its illnesses is very rewarding.

Therese's emotional reactions towards her illness have demonstrated the importance of sympathetic understanding and of firmness blended with gentleness. I am convinced that to remove all perspective of pain from a child's mind, is not doing her a service. The child must be helped to see her illness positively. In the present case, the sick child reacted with good sense towards her illness. No doubt this experience will help her to face difficulties in the future.

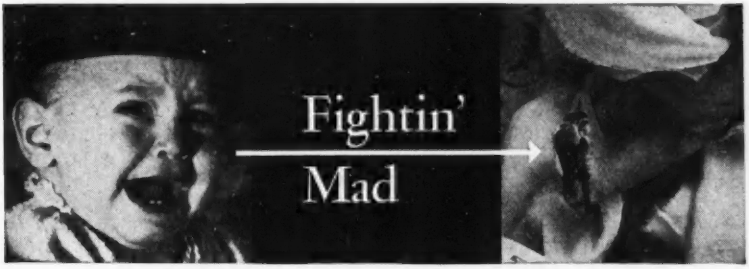
Keeping a patient "walking" during surgery may prevent the formation of death-dealing blood clots. When movement in leg muscles is reduced — as during surgery — the blood pools in the legs and conditions are set up for the formation of blood clots.

By keeping the patient "walking" through the electrical stimulation of the muscles of the leg, this pooling is reduced. The stimulation causes the muscles to contract as they do in walking and this forces the blood back to the heart.

— *The Health Bulletin*,
North Carolina State Board of Health

A safety device for sleepy motorist has been invented by two Italian mechanics. It may help to reduce the number of automobile accidents. The device is an anti-sleep steering wheel called a *guardian halo*. A metal ring fits almost flush with the ordinary steering wheel. When the device is switched on, the driver's hand must stay on the steering wheel at all times, exerting enough pressure to push the ring down until it is flush with the wheel. If the pressure is released, a horn blows in the driver's ear and an electric impulse sets off a hand brake.

— *AMA News*.



Babies are up in arms – and so are many OB nurses and supervisors – about messy ink-pad and roller methods of taking footprints.

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No Boundary Lines

APRIL 6, 1959—and Canadian nurses participated in another "first" in their history. It was the first time that a sectional meeting for nurses in conjunction with a convention of the American College of Surgeons had been held in Canada. The four-day program that followed was the culmination of months of planning by nurses in the Montreal area under the direction of Miss Moyra Allen, Associate Professor, School for Graduate Nurses, McGill University and Sister Denise Lefebvre, Director of Institut Marguerite d'Youville. On the closing day it was noted that 1177 graduate nurses and 77 student nurses had attended the sessions as the guests of the American College of Surgeons. They represented several Canadian provinces and a number of American states. Except for the final session, French language and English language programs took place separately.

With Miss Margaret Wheeler, president of the Association of Nurses of the Province of Quebec presiding over the English session and Sister Lefebvre over the French session, the meetings were officially opened in Montreal's Sheraton-Mount Royal Hotel. Dr. Charles E. Hebert, a governor of the College, brought official greetings to the French nurses. Dr. Paul Hawley, Director, American College of Surgeons, welcomed the English-speaking delegates. He recalled that when the College was first founded in 1913, Canadian and American surgeons had co-operated in its organization. Since then Canadian doctors have taken a prominent part in the activities of the College — the current president is a Montreal doctor, Dr. Newell Philpott.

As the years have passed, the nurse has gained increasing recognition as a team member in the care of the sick. This in turn has resulted in a demand for greater specialization within nursing to keep pace with changes in medicine. Dr. Hawley considered the present extent of specialization indicative of the nurse's status in the team. "There are no boundary lines in the care of the sick."

Miss Theresa Lynch, consultant to the College on programs for nurses, described the development of sectional meetings for nurses in conjunction with conventions of the College. Five years ago nurses were invited to attend a sectional meeting of the American College of Surgeons for the first time. The venture was so successful that these sectional meetings have become a regular feature of conventions of College members.

The sessions for both French-speaking and English-speaking nurses were planned to form a unit based on the various aspects of the care involved in treating a specific patient. Under the direction of Dr. Gustave Gingras, professor of physical medicine and rehabilitation, University of Montreal, a panel including a surgeon, a nurse, a social worker, a psychiatrist, a psychologist and an occupational therapist presented to the French-speaking nurses a picture of the care required for a patient who had had a double leg amputation as the result of osteomyelitis. Mrs. Isobel MacLeod, director of nursing, Montreal General Hospital, was the chairman for the panel of nurses and the physiotherapist who described to English-speaking delegates the hospitalization of a boy with 65 per cent burns to his body. A highlight of the morning for the latter group was the personal appearance of the good-looking young man who was the erstwhile patient. His contribution gave testimony to the success of his rehabilitation.

A question period followed each day's presentation. In this particular situation, interest was centred largely on techniques as the representatives compared surgical routines of their individual hospitals with the one under discussion. The use of homografts in the treatment of burns aroused considerable curiosity. How are donors chosen? What is the exact function of the homograft? The administration of cortisone or ACTH in the treatment of burns was queried. What is the effect expected under such circumstances? One particularly strong impression gained from this presentation was the very appreciable role that the patient does or may play in his own recovery. It is, perhaps, a factor that is overlooked too often.

Both English and French-speaking nurses discussed the preparation of the nurse for surgical nursing on the following day. The foundation is laid at the undergraduate level and the student must be given opportunities to acquire basic knowledge and skill. She should be aware of the main objective toward which the care of the health team is directed — the restoration of the individual to society as a productive member.

At the graduate level, the surgical nurse can build on her basic experience through

specialization. In relation to this, an in-service program for graduate nurses specializing in surgery was outlined. It was based specifically on burn therapy and encompassed.

a. General principles in the care of burned patients
b. Electrolyte balance
c. Skin grafting
d. Emotional problems of burned patients
e. Rehabilitation of burned patients
f. The philosophy of team nursing
g. The role of the team leader

This program was described by Miss C. Currier, head nurse, Montreal General Hospital.

The emotional factor in illness is receiving increasing attention. With Mrs. Helen Gemeroy, assistant professor of nursing, McGill University as chairman, a group of experts discussed "The Management of Crises in Human Situations" at the third English-language session. Dr. J. T. Boag, assistant professor of psychiatry, McGill University, discussed the effect of hospitalization on patients in general, but in particular the very young and the aged. Separation from home and family and adjustment to the unfamiliar hospital situation constitute a major crisis for many persons. The need for emotional support is great, and in practical terms could be partially achieved through more liberal policies in regard to visiting hours; planning nursing care to allow the patient to have the same nurse for as long a period as possible, etc.

Dr. David Soloman, assistant professor of sociology, McGill University, discussed the ways in which humans tend to resolve crises. Although purporting to be unfamiliar with the nursing situation, his remarks proved highly applicable and heads nodded in agreement as nurses identified themselves with the various mechanisms — the resort to secrecy, to ritual, to restraint — used as a protection against awkward situations. Dr. Lawrence G. Hampson, department of surgery, M.G.H., viewed the problem from the point of view of the person responsible for certain crises, and Mary F. McHugh, postgraduate clinical instructor in the operating room, M.G.H., presented the nurse's role. The questions that followed indicated the interest that had been roused.

Should the fatally ill patient be made aware of his prognosis? This is a recurrent question and as yet there is no general agreement upon the answer. Both psychiatrist and surgeon agreed that questions from the patient in this regard must be answered truthfully. When and how much of the truth should be told depends on the individual situation.

What is the role of the sociologist in the hospital? In Canada, he has no role at the moment, according to Dr. Soloman, but it would seem logical that he should be brought into the hospital picture either to do research or to teach the methods of research since this is his special field.

Human relations is a subject as wide as the world itself. It enters into every aspect of daily life. Applied to the hospital milieu, the development of good relationships between individuals, between departments will determine to a large extent the quality of service provided for the patient. Abbé Charles Mathieu, lecturer in political science, University of Montreal was the chairman of the group that discussed this aspect of hospital life for the French-speaking audience. The members represented a variety of departments within the hospital: Sr. Pauline Maillé, administrator, Hotel Dieu; Sr. Mance Décary, director of nursing, Notre Dame Hospital; Dr. G. Cousineau, anesthetist, Notre Dame de l'Espérance Hospital; Dr. R. Desilets, surgeon, Maisonneuve Hospital; Claire Brault, O.R. supervisor, Notre Dame Hospital; Georgette Martin, staff nurse, Jean Talon Hospital; Cécile Bergeron, medical social worker, St. Justine Hospital.

The relationships existing between the various services make for smooth functioning of the whole institution. The employer has a difficult position to fill. He must avoid any tendency to dictatorship or, the other extreme, undue leniency which will deprive him of authority. He must be able to see the good points in all his employees, and avoid discrimination. The employer-employee relationship must allow for satisfactory recognition of the individual employee; must help the worker to see the overall picture and his role as a member of the team.

With simultaneous translation provided for as many of the listeners as possible, English and French-speaking delegates united for the session devoted to the control of staphylococcal infections. This is a problem common to hospitals in many areas and the very evident interest in the information provided by the speakers testified to the general concern in its control. The panel was composed of persons who are acknowledged experts on the subject: Dr. D. Hugh Starkey, adviser to the Director-General, Treatment Services, D.V.A., vice chairman, Associate Committee on Control of Hospital

Infections, National Research Council; Dr. Paul Dionne, assistant professor of bacteriology, University of Montreal; Dr. Edouard Gagnon, professor of surgery, U. of M.; Dr. André Leduc, bacteriologist, Notre Dame Hospital; Sr. Annette Rose, assistant director of nursing, Notre Dame Hospital; Merle E. Smith, supervisor, Surgical Supply Department, Royal Victoria Hospital; Richard Wickens, administrative housekeeper, Montreal General Hospital. The September issue of the *Journal* is to be devoted to this subject and will include a number of the papers presented.

The subsequent question period brought to light additional aspects of the problem than those touched upon formally.

What should be done about staphylococcal carriers? Studies are to be undertaken in institutions that have experienced virtual epidemics. The conclusions drawn from these should help to clarify the extent to which carriers are a factor. Treatment of carriers in some instances can be a great problem since success is not assured. However it is also known that where *very careful* technique is employed, carriers can work safely in surgery, etc.

What is the use of the plastic mattress cover? If the mattress is placed *completely* inside a plastic bag, then definitely this will protect against the gradual impregnation with the bacteria that is a current hazard.

What is the feeling in regard to the use of plastic face masks? The Minneapolis mask is one of the newest forms of surgical mask. The principle involved is direction of the expired air to outlets near the ears where it passes through filtration discs. Tentatively the mask appears somewhat clumsy with a tendency to obstruct vision and to make breathing uncomfortable. The surgeon on the panel expressed his belief that the familiar cotton face masks are still effective if talking is reduced to an absolute minimum, and then conducted in low tones; if the mask is changed at intervals when the operation is a lengthy one.

Consideration of all possible aspects leads to the conclusion that careful aseptic technique is still the first and main line of defence against infection. There should not be too much reliance on antibiotics since indiscriminate use of these preparations is known to lead to the development of resistant bacterial strains and subsequent complications.

A variety of tours to city hospitals and health agencies filled the afternoons. Historic Hotel Dieu Hospital which this year celebrates its tercentenary opened its doors to interested visitors. The Cardiology Institute of Montreal connected with Maisonneuve Hospital demonstrated techniques and equipment related to cardiac surgery. St. Justine's Hospital also displayed its cardiology department plus other features. At the Montreal Children's Hospital, members of both the medical and nursing staffs combined to present, through panel discussions, two very interesting features of the institution — the constant care unit, and the mother and child unit. Recovery rooms are becoming a familiar part of hospital life. The constant care unit enlarges this service to increase the effectiveness of the care offered to the patient. Provision of mother and child units is based on recognition of the fact that the young child, in particular, can suffer deep emotional distress as the result of separation from family and familiar surroundings.

The Montreal General Hospital provided for tours through operating room and recovery room suites. The nursing staff of the operating room cooperated in preparing a most interesting exhibit related to its undergraduate and postgraduate educational programs as well as other features. Many delegates participated in the tour of the Occupational Therapy and Rehabilitation Centre where an average of 90 patients per day receive training that will eventually help to restore them as productive citizens.

These are only a few of the institutions that were included in tour arrangements. Both French and English institutions cooperated generously in making arrangements to entertain the nurses and display particularly interesting or unusual features in their facilities. Johnson and Johnson Company, Montreal branch, very graciously arranged to have delegates visit their plant.

The noon hour of each convention day was used for film viewing. The names of the films and the sources from which they can be obtained are included for the convenience of those who may wish them for teaching purposes. Some of the films are very recent productions, all of them can be commended for the excellence of the material presented.

1. *Positioning the Patient for Surgery*
   North American Cyanamid Ltd.,
   5550 Royalmount Ave.,
   Montreal.
2. *Transporting the Patient for Surgery*
   North American Cyanamid Ltd.
3. *How to Conduct a Discussion*
   National Film Board,
   3255 Cote de Liesse Rd.,
   Montreal.

4. *Production 5118*
   Sovereign Film Distributors Ltd.,
   1200 St. Alexander St.,
   Montreal.
5. *Embryology of Human Behavior*
   Educational Filmstrip Distributors,
   1900 Fairmount Ave., Ottawa,
   Box 3040.
6. *Home Care*
   Department of Education,
   Regina, Sask.
7. *All My Babies*
   Canadian Film Institute,
   142 Sparks St.,
   Ottawa.
8. *A Nurse's Day with the Mentally Ill*
   Canadian Film Institute.
9. *Going to Hospital with Mother*
   Canadian Film Institute.
10. *Student Nurse*
    National Film Board.

The expressions of thanks and appreciation extended on the closing day were most sincere. Thanks to the American College of Surgeons for their very great generosity in making the opportunity for this nurses' sectional meeting possible. Thanks to the chairmen and members of the planning committee who worked quietly, tirelessly and efficiently to carry out the myriad details involved in program production. It was the first time that this sectional meeting had been held in Canada — the first, it is hoped, of more to come. J.E.M.

Portable dental equipment which may enable dentists to give home care is presently being tested. It consists of instruments which can be operated from an ordinary household outlet.

— U.S. Dept. of Health, Education and Welfare

Book Reviews

The Family Handbook of Home Nursing and Medical Care by I. J. Rossman, M.D., Ph.D. and Doris R. Schwartz, R.N. 403 pages. Random House Inc., 457 Madison Ave., New York 22. Price $4.95.

Reviewed by Mrs. Kay Anderson, 359 West 26th St., North Vancouver, B.C.

This is a comprehensive reference book for any person who finds herself facing the care of a patient in the home. The authors describe it as "a guide to what to do after the doctor has gone," and this it truly is. It is well indexed for quick reference to any particular problem. It outlines the problems arising generally from having an ill person in a household of well people. It deals specifically with the bedside care of a variety of illnesses and the different approaches necessary to different age groups.

Stress is placed on a knowledge of good health as a weapon against illness and on a knowledge of the community resources available to assist in home care. The art and techniques of nursing are explained. An understanding of both the patient and his illness is emphasized. There are particularly good sections devoted to specific treatments and special diets; and a well-illustrated chapter on bedside procedures such as giving injections, taking pulse and temperatures, restraint of a bed patient, etc.

Anatomical and physiological explanations are simply and clearly stated so that the home nurse has an understanding of the aims of treatment and is prepared to interpret the doctor and the patient to each other.

Medical-Surgical Nursing by Kathleen Newton Shafer, R.N., M.A., Janet R. Sawyer, R.N., M.A., Audrey M. McCluskey, R.N., M.A. and Edna E. Lifgren, R.N., M.A. 989 pages. The C.V. Mosby Company, St. Louis, Mo. 1958. Price $8.75.

Reviewed by Miss Jean Anderson, Director of Nursing, Victoria Public Hospital, Fredericton.

Four nurse educationists have collaborated to present an excellent reference book on comprehensive patient care. Throughout the text the individuality of the patient is stressed, rather than his disease — "work towards responding to each patient individually." The text is divided into two sections:

1. General Conditions (Trends and Problems Influencing Patient Care).

2. Nursing Related to Specific Medical-Surgical Care.

The first section discusses the patient — with pain, with problems of electrolyte balance, with the problem of old age, etc. Of particular note is the chapter on "The Nurse's Role in Accidents, Emergencies."

The discussion of the care of the disaster

patient is excellent. One criticism of this chapter, as of all others, is that as a possible student nurse text, I feel that listings of symptoms or in this particular area, action to initiate should have been included to allow for rapid review and quick reference.

The second section dealing with specific conditions, both medical and surgical, is most comprehensive. The regime necessary, the clinical investigation to be done, the drugs used and their actions, are all discussed in detail. The actual nursing treatments, unfortunately, are given less attention — in fact, the nurse is referred back to her nursing principles text.

Chapter 21, "Disorders of the Urinary Tract" could be used to replace a text on genitourinary conditions. No condition or phase of care is overlooked. The explicit directions for home care of patients with catheters would be most helpful to the public health nurse. I believe the review questions at the beginning of each chapter should be valuable to both student and graduate nurse alike.

Because of the extreme length and detail of each chapter and because of the tendency to refer to the student's own text on nursing instead of outlining nursing care, I feel this book is unsuitable as a classroom text. It would be a valuable reference book on comprehensive patient care.

Personal, Impersonal and Interpersonal Relations by Genevieve Burton, R.N., Ed.D. 230 pages. Springer Publishing Company Inc., 44 East 23rd. St., New York 10. 1958. Price $2.75.

Reviewed by Miss E. James, Director, Centralized Teaching Program, Regina College, Regina.

The preface of the book states its purpose, "The major goal . . . is to increase insight and understanding on the part of nurses which will lead to improved interpersonal relations in whatever situation a nurse may find herself." The author admits that the motivation to write came from the expressed needs of experienced practising nurses but the text is primarily intended as a guide for the young, inexperienced nurse.

The material is presented in two parts. The basic psychological and sociological concepts of the human organism from birth to old age are discussed in the first section. The normal development of personality is illustrated by case studies. Our emotional needs and the means by which they are met are outlined. The effect of illness on both personality and emotions is discussed.

In the second section it is assumed that the nurse, by virtue of her relationships with patients and their families, will be drawn into the role of counsellor whether she wishes it or not. Careful guidance is given on how she can use her knowledge to help those with whom she comes in contact without usurping the place of the specially trained counsellor. Both areas of material should be useful to the nurse, either young or more mature, who is studying the social sciences for the first time. It should be particularly helpful in orienting the nurse to her place as a counsellor. A recommended reading list at the end of the book directs the reader to broader fields of understanding.

The last chapter in the book has great appeal. The nurse is urged to "know herself." After studying in an objective way the usual and peculiar qualities and behavior of others, the reader is asked to become subjective and see these same qualities and behavior in herself. This is the key to the usefulness of the book. A nurse cannot use the concepts outlined until she develops "empathy" by knowing, admitting and being able to cope with her own emotional needs and motivations. She must practise "empathy."

The author has artfully woven the term "Impersonal Relations" into her title. She supports the belief that the nurse must remain emotionally uninvolved with her patient but her interpretation of impersonal relationship implies a warm, supportive role, not a cold, reserved withdrawal. Any nurse could benefit from a study of this book.

Principles of Ethics by Dom Thomas V. Moore, M.D., Ph.D. and Dom Gregory Stevens, S.T.D. 282 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 5th Ed. Price $6.00.

Reviewed by Sr. Denise Lefebvre, Director, Institut Marguerite d'Youville, Montreal.

Student nurses, for whom this book was written especially and graduate nurses will find in this volume the basic moral principles directing conduct, expressed in a simple, clear and concise form. A careful study of the content should be helpful in developing sound ethical judgment and in giving a richer appreciation of human life.

This book has always been considered a "classic" of its kind. It treats masterfully "a wide range of moral questions for which a correct solution is offered and prudent advice and counsel is given." "The revision preserves the manner and inspiration of the original work" while it gives careful consideration to recent trends in moral philosophy and their implications in the work of the nurse.

The book is divided into two parts. Part one deals with the general ethical principles fundamental to a true understanding of human behavior. Part two discusses various facets of the moral life. Prudence, justice, fortitude, temperance, the social virtues, friendship, the civil law, religion, morality of sexual life, principles of married life, form the content of 17 chapters.

Other aspects of the preparation of a nurse are also considered. Among these are the building of personality through self-knowledge, self-esteem and self-improvement; the development of one's cultural and intellectual capacities; the importance of an interest in good reading, the fine arts or similar constructive form of recreation; ways of spending leisure time to enrich life and deepen personal and cultural maturity; the cultivation of a balanced sense of propriety and good taste as manifested in one's general bearing, dress, appearance and in conversation.

Each chapter is followed by a brief summary, useful for review. Questions and problems for discussion are added. A bibliography and list of selected readings complete each chapter. Throughout the book, constant reference is made to the particular moral and ethical problems of the nursing profession.

In reading this text, the nurse will be impressed to realize how intimately in her everyday work, basic ethical principles find their application and how important it is for her, because of her public and professional status, to cultivate all the aspects of human virtue. In our modern world where materialism is prevalent and real values are questioned, this book "offers the nurse thoroughly validated fundamental principles upon which to build a body of resources essential to lasting integrity."

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Registered Nurses for a large expanding City Hospital in Edmonton, Alberta for summer relief & permanent employment. Experience available in all departments including oprating rooms & case rooms. Credit given for postgraduate work & past experience. Opportunities for advancement. Liberal sick leave, vacation, 40-hr. wk. General Duty $255-$285 per mo. plus laundry. Staff Nurses $285-$315 per mo. plus laundry. For particulars apply to: Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Registered Nurse for 35-bed busy General Hospital offering a variety of experience. 40-hr. wk., rotating periods of duty. Gross salary $270 per mo. $35 deducted for maintenance & laundry. 4 semi-annual increments of $5.00, 3-wk. vacation, 10 statutory holidays, 12 days sick leave yearly, cumulative to 30 days. Accommodation in hospital wing — single & double rooms. Viking is 90-mi. southeast of Edmonton, on main highway & railway with daily bus & train service. Apply to Matron-Supt., Municipal Hospital, Viking, Alberta.

Registered Nurses for General Duty Staff. Salary $275 per mo. 4 semi-annual increments. Board & room $30 per mo. Paid overtime, 42-hr. wk. 1-mo. paid vacation, sick leave 1½-day per mo. accumulative to 90-days. Apply stating age & qualifications, to: Matron, Municipal Hospital, Mayerthorpe, Alberta.

Registered Nurses or Graduate Nurses (2) for General Duty in 16-bed hospital. Salary schedule according to the current A.A.R.N. suggested schedule. Basic salary $255 for R.N. plus increment increases according to experience. Hospital is centrally located between two (2) Lake resorts etc. Apply to: Mrs. J. Bergquist R.N. — Matron, Municipal Hospital #43, Bentley, Alberta.

General Duty Nurses (Immediately for summer relief & steady employment) new 54-bed hospital. Gross salary $255 per mo. with annual increase, less $26 maintenance, 1-mo. vacation after 1-yr. service. Voluntary pension plan & compulsory medical & hospitalization plan in operation. Apply stating references & experience, if any, to: Matron, Municipal Hospital, Vermilion, Alberta.

Graduate Nurses (2) for small country hospital in northern Alberta (40-mi. paved road to next city). Starting salary for R.N., $265; for Gr.N., $250 less $30 room & board. Good working conditions. Foreign nurses are given opportunity to register in Alberta after 1-yr. service. Newly decorated residence, single rooms. Apply: Matron, Hythe Hospital, Hythe, Alberta.

Graduate Nurses for 56-bed hospital. Pleasant working conditions. Apply to: Mrs. A. Kerby, R.N., Superintendent, Municipal Hospital, Stettler, Alberta.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: The Matron, Municipal Hospital, Bassano, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk. with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

Nurses (2) immediately for 20-bed hospital, 40-hr. wk. Wages $285 plus annual raises; 4-wk. vacation after each year's service. Living in quarters available. Apply to Matron, Coronation Municipal Hospital District No. 39, Coronation, Alberta.

BRITISH COLUMBIA

Nursing Supervisor (B.C. Registered) for Community owned 18-bed hospital, with new 26-bed hospital under construction. Starting salary $325 per mo. Full maintenance $48 per mo., in new modern nurses' residence, Scenic location in Rocky Mountains west of Calgary, Alberta on Trans Canada Highway. For full particulars write: C. F. Collins, Secretary, General Hospital, Golden, British Columbia.

Supervisor of Nursing for 40-bed General Hospital, a very active western town in the world famous Cariboo ranching country. Construction of new 100-bed, double corridor design, 5-story hospital to start this fall. All applications considered but preference to graduate in nursing administration. Quarters in nurses' home, 40-hr. wk. 28 annual & 10 statutory holidays, 1½-days sick leave per mo. accumulative, position vacant July 1, 1959. State age, experience & references in first letter to: Adminstrator, War Memorial Hospital, Williams Lake, British Columbia.

Registered General Duty Nurse for 30-bed hospital. Starting salary $260 per mo. with $10 yearly increment. Board & room $40, 1½ day sick leave per mo. 40-hr. wk. 11 statutory holidays & 28 days vacation after 1-yr. service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

Laboratory Technician (1) X-Ray Technician (1) fully qualified; **Registered Nurses** (3) for 30-bed hospital in Central B.C. on the Jasper Prince Rupert Highway, 70-mi. from Prince George. Salary for each of the above positions $290 per mo., 10 legal days with pay per year; 1½-days sick leave per mo., 28-days vacation after 1-yr. Laundering of uniforms by hospital; modern nurses' residence $50 per mo. Also **Certified Practical Nurses (3)** salary $190 per mo., 1½-days sick leave per mo. 10 legal days with pay per year; 2-wk. vacation after 1-year. Kindly apply giving qualifications & references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

Head Nurses for Operating Room: 42-bed pediatric unit in 434-bed hospital with nurses' training school. Postgraduate or equivalent experience required, B.C. registration required, 40-hr. wk., statutory holidays, 28-days annual vacation. Credit given for past experience & postgraduate preparation. Salary $295-$354. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty Nurses for small active hospital. Salary $250 for unregistered. $260 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for new 60-bed acute General Hospital on Vancouver Island R.N.A.B.C. contract in effect, new residence, good personnel policies. Further information from Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

General Duty Nurses for General Hospital with school of nursing. Salary $275-$327 per mo. B.C. registration essential. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed General Hospital located in British Columbia's beautiful Northwest. Salary $283 per mo. with $10 increments for 3 years. Modern residence facilities available. For complete information apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $270, maintenance $47.50; 40-hr. 5-day wk. 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Generous personnel policies, nurses' residence. Apply: Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $280-$336. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed General Hospital. Salary $260-$280; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 yr. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses: for new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For salary rates & personnel policies, apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses for 37-bed hospital, salary $250 per mo. with annual increments — 28-dy. annual vacation, cumulative sick leave. $50 monthly board, lodging, laundry. New 50-bed hospital to be erected 1959. Apply: Administrator, Terrace & District Hospital, Box 1297, Terrace, British Columbia.

MANITOBA

Matron, Registered Nurse & Licensed Practical Nurse for 8-bed hospital soon to be enlarged to 15-beds with new surgical & patient facilities. Basic salaries of $325, $290 & $200 gross per mo. 4-wk. vacation with pay per yr. after 1-yr. service. Daily bus service to Brandon & Winnipeg. Duties to commence as soon as possible. Apply: Sec.-Treas., Mrs. A. E. Owen, Reston, Manitoba.

Registered Nurse (for general floor duty) Salary $290 per mo. less $25 for full maintenance, yearly increments, 44-hr. wk. For further information apply to: John Hiscock, Secretary-Treasurer, Baldur Medical Nursing Unit, Baldur, Manitoba.

Registered Nurses (2) as soon as possible for 16-bed hospital. Salary $280 per mo. gross, $40 per mo. deducted for board & room. 40-hr. wk. 3-wk. vacation with pay after 1 full year employment, 4-wk. after 2 full years. Sick leave one day for each full month of employment plus 1 day for each full 6-mo. employment cumulative to 30 days. Living quarters in hospital. Apply to A. C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered Nurses (2), **Practical Nurses** (2) for 30-bed hospital. Salary $285 & $185 respectively. Board & room $35. Minor & major surgery. 44-hr. wk., vacation pay, statutory holidays, paid sick leave. Apply: Administrator, DeSalaberry Hospital, St. Pierre, Man.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NEW BRUNSWICK

Clinical Instructor Medical & Surgical Nursing. 1-class a year. For further information please apply: Superintendent of Nursing, Charlotte County Hospital, St. Stephen, New Brunswick.

Head Nurses & General Staff Nurses for new 26-bed phyciatric division opening July 1, 1959. Apply to: Director of Nursing, Saint John General Hospital, Saint John, New Brunswick.

NOVA SCOTIA

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

ONTARIO

Assistant Director of Nurses, Registered Nurses for General Duty in new 50-bed hospital. Apply: Superintendent, Meaford General Hospital, Meaford, Ontario.

Lady Superintendent & Administrator for small well equipped General Hospital in a community of 3,000 people & serves a fairly large rural area; situated close to Ottawa, there is a good rail & road communication with the Capital & other communities in the Ottawa valley. Applicants are requested to provide reference with a resume of past experience & salary expected. Apply: Secretary-Treasurer, The Rosamond Memorial Hospital, Almonte, Ontario.

Superintendent of Nurses (with administrative qualifications) for modern 32-bed hospital to be opened early in 1960. Situated in one of Eastern Ontario's most progressive communities, close to Ottawa & U.S. Border. A small apartment is provided in the hospital. Applicants are requested to provide a resumé of past experience & salary expected. Apply to: Secretary-Treasurer, District Hospital, Box 248. Kemptville, Ontario.

Registered Nurses for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses (2) for small well equipped hospital, 30 miles from Ottawa. Liberal salary. Apply: Superintendent, The Rosamond Memorial Hospital, Almonte, Ontario.

Registered Nurses for 73-bed General Hospital on Lake of Woods. Tourist & industrial town of 10,000. General duty salary $265-$295 for nurses currently registered; $245 for non-registered qualified nurses. Excellent personnel policies. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Registered Nurses: See beautiful Northern Ontario & enjoy life in the heart of Canada's gold mining district. Additional staff required for new 60-bed addition opening about June 1st. Salary $255 per mo. to start, with above average personnel benefits. Accommodation available in residence. Transportation can be arranged if necessary. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses (2) for an active 50-bed General Hospital in an attractive business town 100-mi. northwest of Toronto. Excellent salary plus full maintenance. For further information please apply to: Superintendent, Memorial Hospital, Listowel, Ontario.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic Northwest Territories and the Yukon Territory.

SALARIES

(1) Public Health Nursing Supervisors: up to $5,220 depending upon qualifications and location.

(2) Directors of Nursing in Hospitals: up to $4,950 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $3,780 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,540 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses for 200-bed hospital for extended illness. Residence accommodation. Apply to: Director of Nursing, Parkwood Hospital, 81 Grand Avenue, London, Ontario.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital, Starting salary: $265 per mo. plus shift allowance. 40-hr. wk. 4 wk. vacation after 1 yr. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for medical, surgical & pediatric services in new General Hospital. Apply: Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ontario, Canada.

Registered Nurses (Toronto Area) for 30-bed hospital for chronic illnesses. Salary $12 per day; 5-day wk.; 3-wk. vacation per year. Apply: L. Mackie, Director of Nursing, The Villa Private Hospital, Box 490, Thornhill, Ontario.

Registered Nurses & Certified Nursing Assistants for General Duty in all services. Salary commensurate with experience & qualifications, good personnel policies. Apply to: The Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

Registered Nurses & Nursing Assistants (for regular staff & summer relief) in 47-bed hospital, tourist town, good personnel policies, full maintenance in residence. Apply: Superintendent, General Hospital, Kincardine, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience. $5.00 increment every 6-mo. 44-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo. 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty in all departments including operating room. Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Jamestown, Ontario.

Registered Nurses for General Duty in all departments including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty starting salary $250 per mo., 44-hr. wk., sick leave, 3-wk. vacation. Apply: Superintendent, Public Hospital, Smiths Falls, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000 **Salary: $260 per** mo. with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses for 28-bed General Hospital. Salary & personnel policies in accordance with R.N.A.O. Adjacent attractive residence, recreation facilities. For further information please apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

General Duty Nurses for 65-bed modern hospital. Salary & personnel policies upon application to: Director of Nurses, Memorial Hospital, Campbellford, Ontario.

General Duty Nurses for 100-bed hospital. Salary $260 month with recognition for P.G. Courses, 44-hr. wk. at present. Up-to-date facilities in a beautiful location on the shore of Lake Erie. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260. Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7-mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Operating Room Nurse for new 105-bed hospital on shores of Georgian Bay. 40-hr. wk. For salary, rates & personnel policies apply: Director of Nursing, St. Andrews Hospital, Midland, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $250 per mo., 40-hr. wk. Good personnel policies for other benefits. Resident accommodation available. Apply to: The Director of Nursing.

Graduate Nurses (Close to Metropolitan Toronto) for 120-active bed County Hospital with up-to-date facilities located in a friendly community, 1-hr. bus ride to downtown Toronto. Salary $245-$285, residence accommodation available. Adequate staffing & personnel policies. Apply: Director of Nursing, York County Hospital, Newmarket, Ontario.

The Roosevelt Hospital

428 WEST 59th STREET • NEW YORK 19, N.Y.

APPLICATION FOR APPOINTMENT
NURSING SERVICE DEPARTMENT

NAME (PRINT) .....

ADDRESS .....

.....

BIRTHDAY ..... MARITAL STATUS .....

WHERE REGISTERED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

PROFESSIONAL BACKGROUND

BASIC NURSING & POSTGRADUATE COURSES	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL AND LOCATION	DATE

TRANSPORTATION FROM CANADA PAID UPON APPOINTMENT TO STAFF

COMMENTS:

PLEASE INDICATE IN NUMERICAL ORDER, NURSING SERVICE PREFERRED:

☐ MEDICINE ☐ MEDICINE & SURGERY ☐ PEDIATRICS
☐ SURGERY ☐ OPERATING ROOM ☐ GYNECOLOGY

SEND TO: DIRECTOR, NURSING SERVICE
THE ROOSEVELT HOSPITAL
428 WEST, 59th STREET
NEW YORK 19, NEW YORK

SUDBURY GENERAL HOSPITAL

of the

IMMACULATE HEART OF MARY

ON LAKE RAMSAY

Operated by the Sisters of St. Joseph
370 beds — built in 1950

Services in Medicine, Surgery, Pediatrics, Obstetrics, Gynecology, Psychiatry.

Opportunities for Nursing Instructors and General duty nurses.

40-HR. WK. BEGINNING SALARY $260.

APPLY, DIRECTOR OF NURSING, SUDBURY GENERAL HOSPITAL SUDBURY, ONTARIO.

REGISTERED NURSES — $3,000 - $3,540

(According to Qualifications)

CERTIFIED NURSING ASSISTANTS — $2,040 - $2,400

SUNNYBROOK HOSPITAL, TORONTO **WESTMINSTER HOSPITAL, LONDON**

Pension Plan; three weeks' paid vacation; three weeks' accumulative sick leave; 5-day week; low-cost living in staff residence — for Nurses; application forms available at your nearest Civil Service Commission Office, or main Post Offices, should be forwarded to the Civil Service Commission, 25 St. Clair Avenue East, Toronto 7, as soon as possible.

Public Health Nurse (qualified) for completely generalized program. Salary range, pension plan & other personnel policy given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurses for generalized program in Seaway Development area. Good transportation policy & pension plan. Apply to: Mr. L. C. Kennedy, Secretary-Treasurer, Board of Health, Stormont, Dundas & Glengarry Health Unit, County Buildings, Cornwall, Ontario.

Public Health Nurses (generalized program) minimum salary $3,300 with allowance for experience & annual increments. Generous provision for transportation. For further details write: Dr. R. M. Aldis, Director, Huron County Health Unit, Goderich, Ontario.

Public Health Nurses (qualified) for generalized program, urban & rural. Salary $3,500 - $4,250, annual increment $150, pension plan, P.S.I., 4-wk. vacation. Apply: Archie F. Bull, M.D., D.P.H., Director, Halton County Health Unit, Milton, Ontario.

Texas: Registered Nurses, (English speaking) for rotating shifts. Salary $290-$315, 40-hr. wk., living facilities available. Hospital operated by Daughters of Charity. Apply: Director of Nursing Service, St. Paul Hospital, Dallas 4, Texas.

Staff Nurses (All services) Texas teaching hospital. Air conditioned; good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Operating Room Nurses, General Duty Nurses get away from fog, smog & industrial areas. Come to exciting wonderful Wyoming. 340-days sunshine, fresh air in year-round recreation area. Position vacancies, all shifts & types. 165-bed JCAH Hospital with expansion program. Capitol city, growing medical center Wyoming. 50,000 pop. Home of Frontier Days & Warren Air Base. Metropolitan Denver 2-hr. drive from Cheyenne. Excellent personnel policies. 40-hr. wk., 2-3 wk. vacation, sick leave. New nurses' residence at reasonable rates. Excellent housing facilities within 10-min. of hospital. Excellent starting salaries. Apply. Director of Nursing, Memorial Hospital, Cheyenne, Wyoming.

Public Health Nurses (Qualified) for a generalized program in suburban & rural areas with Peel Country Health Unit. Unit headquarters near Toronto. Salary range $3,400 - $4,200. Annual increment $150; pension plan, car allowance, cumulative sick & holiday leave. Optional Blue Cross & P.S.I. protection. Apply to: Mrs. Helen Littleton, Supervisor of Public Health Nursing, 44 Nelson Street West, Brampton, Ontario.

Registered Nurses (Immediately & later) for General Hospital. Salary $300 per mo. & full maintenance. Previous obstetrical & operating room experience necessary. New Hospital, comfortable nurses' residence. Apply to: Matron, General Hospital, Mayo, Yukon Territory.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses (Qualified) for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370, annual increment $175, starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Ontario.

Public Health Nurse (Qualified) for generalized program 20-mi. from Toronto. Salary $3,500 - $4,250 effective July 1st; allowance for experience, annual increment $150, 4-wk. vacation, cumulative sick leave, hospitalization & shared medical & surgical group in effect, pension plan. Apply: The Director, Ontario County Health Unit, (Southern Area), Pickering, Ontario.

Public Health Nurses (Qualified) for Victorian Order of Nurses (Toronto Branch). Minimum salary $3,432, consideration given to past experience. Annual increments, 5-day wk., 4-wk. vacation, $100 uniform allowance, PSI & supplementary Blue Cross available. Pension plan benefits. Apply: Director, 281 Sherbourne Street, Toronto 2, Ontario., WA. 1-3184.

Public Health Nurse for generalized program. Basic salary $3,300 with annual increment of $175, other personnel policies on request. Apply to: Supervisor of Public Health Nursing, Oxford Health Unit, Woodstock, Ontario.

Operating Room Scrub Nurse for modern well equipped 40-bed General Hospital. 40-mi. from Ottawa. Apply giving qualifications & salary expected to: The Superintendent, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Director of Nursing Service for Metropolitan Toronto Hospital with university degree or equivalent courses, some experience in supervision or administration. Salary $450 per mo., 40-hr. wk., 3-wk. paid vacation, accumulative sick leave. Direct your reply to: Box H, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Educational Director, unusual opportunity in unique well-staffed hospital well known for both scholastic standing & bedside patient care. Excellent work situation, warm, friendly atmosphere, above usual remuneration, excellent housing & personnel policies. Midwest location in rapidly developing industrial area, 3-yr. program, 100-students, completely new facilities, college affiliation. State approved, desire accreditation. Present director retiring. Apply: Box F, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Que.

Assistant Head Nurses excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses — General Staff for large psychiatric hospital (preferably postgraduate) with possibility for rapid promotion. 15-min. from downtown Montreal. Good residential facilities available. Write: Personnel Officer, Box 6034, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital in Huntingdon, Quebec, 45-mi. from centre of Montreal with excellent bus service. Gross salary $235 with full maintenance in nurses' home at $35; 3-increases at 6-mo. intervals to $250; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays; 2-wk. sick leave, Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., Huntingdon County Hospital, Huntingdon, Que.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for 95-bed hospital. New nurses' residence. For particulars write to: Director of Nursing, Lloydminster Hospital, Lloydminster, Saskatchewan.

Registered Nurses (2) for 19-bed hospital. Gross salary $260 with increments & benefits as per S.R.N.A. Nurses' residence on grounds with T.V. Apply: Union Hospital, Vanguard, Saskatchewan.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts, evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $315 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

General Duty Nurses (English speaking) 500-bed General Hospital in Sunny Southern California. $315-$360 base plus $15 shift differential until California Registered. $330-$375 base a month plus $33 shift differential upon registration. Employee health & pension plan. Generous holiday & vacation benefits. Nurses' residence located on grounds. For information apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

General Duty Nurses (California, between Sacramento & San Francisco) for 84-bed general short term JCAH hospital. Starting salary $325, nurses' home, excellent working conditions. Write, Director of Nurses, Clinic Hospital, Woodland, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30-days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chesnut Avenue, Long Beach 13, Calif.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, Liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Operating & Delivery Room Nurses (English speaking) 500-bed General Hospital in Sunny Southern California. $325-$370 month base plus $15 shift differential until California Registered. $340-$385 month base plus $33 shift differential upon registration. Employee health & pension plan. Generous holiday & vacation benefits. Nurses' residence located on grounds. For information apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $340 for days, $370 for evenings, $360 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Registered Nurses for new 750-bed municipal hospital. Salary $3,700 per year with $100 yearly increments reaching maximum of $4,200; 40-hr. wk., vacation, sick time & 12 holidays, 1 meal & laundry of uniforms provided. Apply to: Director of Nursing, Martland Medical Center, Newark, New Jersey.

School Nurse (Registered) for small infirmary in girls' private school 20-mi. from N.Y.C., pleasant opportunity. Apply: P.O. Box 308, Summit, New Jersey.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Clinical Instructor, unique hospital school located in rapidly developing industrial area. 100-students, basic program, college affiliated. Splendid opportunity for recent graduate, in friendly atmosphere, devoid of the usual tensions & conflicts. Better than average salary & personnel policies. Apply: Personnel Director, Holzer Hospital, Gallipolis, Ohio.

Registered Nurses (Oregon observing Centennial Year, packed with exciting activities, including International Trade Fair.) for 310-bed General Hospital affiliated with University of Oregon Medical School. **Staff Nurses** basic salary $309 with annual increases to $361. **Asst. Head Nurse** $316-$386, **Head Nurse** $385-$438, opportunities for advancement. Full-time evening & night nurses given asst. head nurse classification, plus $10. Paid vacations, sick leave, holidays, soc. security. Multnomah Hospital, Portland, Oregon.

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For all Departments in a new 116-bed, 40-bassinettes, hospital. Positions available now in the Obstetrical and Emergency Department.

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ST. JOSEPH'S GENERAL HOSPITAL, ELLIOT LAKE, ONTARIO

OPC

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This position in a well organized health service for all staff & students is open in the early fall. Requirements necessary is experience in public health field with an appreciation & understanding of a referral system to community health agencies. Salary commensurate with experience & qualifications.

Apply to: The Director of Nursing
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WOODSTOCK, ONTARIO

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General Staff Nurses — All Departments

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NORTHWEST REGIONAL HOSPITAL COUNCIL,
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IMMEDIATELY. COMPETITION NO. 59:152

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General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton. $260 gross salary for Alberta registered, $250 gross salary non register in Alberta. Excellent personnel policies & working conditions. Apply: Matron, Municipal Hospital, Brooks, Alberta.

Operating Room Graduate Nurse (Duties to commence September 1, 1959) 76-bed General Hospital near Calgary & Banff. Gross starting salary $270 per mo. if registered in Alberta. Excellent personnel policies. Apply: Matron, Municipal Hospital, Brooks, Alberta.